PART 5
REGISTERS

Provisional Proposal 5-1: The statute should set out a core duty on all the regulators to establish and maintain a professional register.

5.1 All consultees who expressed a view supported the proposal that the statute should set out a core on duty on all the regulators.[1] For example, the Chartered Society of Physiotherapy stated that:

> Establishing and maintaining registers is the primary statutory function of regulators and the fundamental way in which they fulfil their public protection role. It is from holding and maintaining a register that all other regulatory activities stem (including managing admission to the register, the renewal and review of registration, and the management of fitness to practise cases that may remove an individual's eligibility to remain on a register).

5.2 Similarly, the Association of Regulatory and Disciplinary Lawyers described professional registers as the "centrepiece of statutory regulation". The Patients Association felt that, for the public, the register is "a stamp of accreditation of the abilities, skills and qualifications of a professional" and that "registration inspires a certain amount of trust and confidence in individual registrants".

5.3 The Professional Standards Authority suggested changing the term "professional register" to "register of professionals" since the former could be interpreted as describing a register that is run "for the benefit of professionals".

5.4 Some consultees argued for greater consistency over how this duty is implemented. For example, both the Association of Regulatory and Disciplinary Lawyers and the Patients Association called for certain core features of professional registers to be enshrined in legislation, such as qualifications, registration status, specialism, name, title, gender and sanctions.

Provisional Proposal 5-2: The regulators should have the ability but not a duty to appoint a Registrar.

5.5 A significant majority agreed that it should be left to the regulators to decide whether or not to appoint a Registrar.[2] For example, an individual consultee (Jane C Hern) said that:

> The appointment of a Registrar is not essential; much of what is required can be undertaken by suitably qualified members of staff, supported by committees setting policy, determining unusual cases and for hearing appeals.

[1] Of the 192 submissions which were received, 51 expressed a view on this proposal: all agreed with the proposal.

[2] Of the 192 submissions which were received, 41 expressed a view on this proposal: 32 agreed, 8 disagreed, whilst 1 held an equivocal position.

5.6 Some supported the proposal on the condition that it is made clear who has responsibility for the task of registration. The Patients Association stated that:

> While we agree with the proposal to vest official registration authority in the Council, which may be delegated to a Registrar or other appropriate official, there must be a clear line of accountability for the Council who must be able to be held responsible for errors in the Registers.

5.7 The General Osteopathic Council supported the proposal, but believed that "it is important that the statute recognises the notion of an accountable officer within each regulator".

5.8 The General Medical Council also expressed concern that if the responsibilities currently allocated to the Registrar were distributed among a number of staff members, it could undermine confidence in the regulators. However, it had no strong preference about whether there should be a duty to appoint a Registrar.

5.9 Those who opposed the proposal argued that a Registrar is essential to the regulatory task of registration. The Dental Schools Council stated that:

> It would be impossible and ineffective to set up a register without a Registrar; we would strongly recommend that the legal requirement for the appointment of a registrar is continued. This provides the transparency and accountability for maintaining the register.

5.10 Some made suggestions about the eligibility requirements for appointment as Registrar. The Professional Standards Authority felt that the statute should prohibit the appointment of a registrant Registrar because:

> The powers that are awarded to the Registrar in relation to registration decisions may be considerable; therefore their integrity and independence from the profession should be beyond question.

5.11 The Department of Health, Social Services and Public Safety for Northern Ireland thought that "there would be merit in redefining the role of a Registrar but the concept is essentially good".

5.12 However, the Royal College of Nursing argued that it is appropriate for this role to be carried out by a registrant "in order to maintain public and professional confidence". UNISON argued that the Registrar should not be a dual role for the chief executive.

5.13 The British Society of Hearing Aid Audiologists went further and argued that regulators should not be able to appoint a Registrar, as the "Chief Executive should be directly responsible and accountable for this role".

Provisional Proposal 5-3: The statute should specify which registers must be established by the regulators, including any different parts and specialist lists. The Government would be given a regulation-making power to add, remove or alter the parts of the register and specialist lists.

5.14 A majority of consultees agreed that the statute should specify how the registers must be structured.[3] A large majority agreed with Government regulation-making powers.[4]

5.15 In respect of Government regulation-making powers, the Professional Standards Authority argued that "given the socio-economic impact of regulation" it would not be appropriate to give such powers to the regulators themselves. It stated:

> We believe that in the context of statutory regulation, any decisions to register or specialise a professional group should be based on an assessment of the risk that the group poses to the public, and whether registration or specialist registration is the most appropriate and effective response to this risk. It is therefore important to consider the other means of mitigating these risks that are already available to the regulator, or in place elsewhere.

5.16 The Department of Health argued that:

> The further division of a register or the introduction of a specialist register/list is a decision to restrict the practice of a profession, or a certain level of practice, to a certain group of people. To restrict practice in such a way can have significant political and economic repercussions and therefore it is right that such decisions should be the subject of a formal [Privy Council] power.

5.17 The Scottish Government also supported the proposals. It agreed that changes to the types of registers could potentially "lead to the establishment of new specialities/subspecialties, new protected titles and functions, and the amendment of existing groups". It felt, therefore, that it would be appropriate for the Department of Health and, "within devolved competence", the Scottish Government to make decisions about such changes.

5.18 However, some consultees did not support the proposal. The British Dental Association disagreed that specialist lists should be set in statute, as it did "not see how they are so different from other, even more fundamental, aspects, that will be subject to regulations or rules". The British Pharmaceutical Students' Association also opposed the proposals. It said that:

[3] Of the 192 submissions which were received, 31 submissions expressed a view on this proposal: 22 agreed, 7 disagreed, whilst 2 held equivocal positions.

[4] Of the 192 submissions which were received, 38 submissions expressed a view on this proposal: 29 agreed, 8 disagreed, whilst 1 held an equivocal position.

> Each healthcare profession is different and therefore a one-size-fits-all approach introduced by the Government may not work. Government may also not understand the finer intricacies of each healthcare profession and giving it the ability to add, remove, or alter parts of the register could introduce problems.

5.19 The Nursing and Midwifery Council supported Government regulation-making powers in this area as long as the use of such powers is based on:

> A clearly articulated regulatory rationale for establishing a part of the register or a specialist list, against which proposals to add, remove or alter could be evaluated. This rationale would need to be explicit about why public protection demanded a level of assurance for a specific role above that provided by registration.

5.20 The General Medical Council agreed generally with the proposals. However, it suggested that a distinction should be drawn between specialist registers, which have a clear legal effect, and "specialist lists or credentials which are indicative of a regulatory standard having been attained but which have no direct legal effect". The Council felt that the latter should be left to the regulators to decide "as part of their duty to ensure the utility of the registers they maintain" and the former should be in the statute and subject to Government regulation-making powers.

5.21 The General Dental Council agreed that the statute should specify the different parts of the register and specialist lists. The Council felt that the establishment of new "specialist lists or advance registers" should be for the regulators to decide, subject to consultation rather than "Government approval or veto". This was because:

> Regulators are arguably in a better position to discern whether, in the interests of patient protection, additional specialisms should be recognised and made the subject of additional regulation. Regulators can form this view on the basis of an assessment of its fitness to practise data and other sources which reveal the need for additional regulation in complex areas of the discipline.

5.22 A small number of consultees disagreed with both proposals. The Registration Council for Clinical Physiologists argued that the regulators are best placed to make decisions about the need for specialist lists and that any changes would be more difficult to achieve and take too long if they were left to Government. Similarly, the British Society of Hearing Aid Audiologists argued that a regulator "can consult and act more quickly, will be more in touch with what might be required and bureaucracy will be kept to a minimum".

5.23 The General Osteopathic Council described the proposals as "overly prescriptive". It argued that registers provide useful information for members of the public seeking professional support. The Council also thought it should be possible for regulators "to annotate a register with 'additional information', should the regulator consider it appropriate, rather than necessarily giving it the status of a specialist register".

5.24 The British Association for Counselling and Psychotherapy queried "under what circumstances and with what level of specialist knowledge any government"

would seek to amend the register or specialist lists. The Association feared an increase in legislation.

5.25 Some suggested that new specialist lists should be established. For example, West Sussex County Council referred to Approved Mental Health Professionals under the Mental Health Act 1983 and Best Interests Assessors under the Mental Capacity Act 2005. The Council felt that the important statutory functions of these roles, particularly in relation to powers of detention, should be recognised separately by the Health and Care Professions Council.

5.26 A number of consultees argued that a specialist list should be established for health visitors. For example, the Institute of Health Visiting felt that:

> Treating health visiting as a sub-part of nursing is unhelpful and potentially harmful to the public, because it hampers recruitment and the development of appropriate standards for qualification.

5.27 The Royal College of Nursing argued for "a specialist list of advanced practitioners/nurses working to advanced practice" since "it is important that patients are able to understand and verify that the nurse caring for them is competent to practise at an advanced level".

Provisional Proposal 5-4: The Government should be given a regulation-making power to introduce compulsory student registration in relation to any of the regulated professions.

5.28 A small majority agreed that the Government should be given a regulation-making power to introduce compulsory student registers.[5]

5.29 The Department of Health argued that the power to introduce student registration should be vested in the Privy Council. It also stated:

> Whilst recognising that there are existing student registers, we are not convinced that there is a need to introduce compulsory registration of students. There is an argument that it runs contrary to the purpose of registration to register persons who have not yet successfully completed their degree (ie who by definition are not yet "fit to practise" without supervision), although we can see merits in provisional registration … to allow graduates to complete a year of practical training under the supervision of a university before being registered.

5.30 The Scottish Government agreed with proposal on Government regulation-making powers on the basis that "this is a decision for the Government and, within devolved competence, for the Scottish Government to make".

5.31 Most of those who supported the proposed power did so because they supported the introduction of student registers. Conversely, those who disagreed with the proposal did so because they did not support student registration. Consultees'

[5] Of the 192 submissions which were received, 50 expressed a view on this proposal: 27 agreed, 19 disagreed, whilst 4 held equivocal positions.

views on student registration are covered in the following section, in response to the consultation question whether student registration should be retained.

5.32 The General Optical Council – which is the only regulator that has a compulsory student register – supported the proposal on Government regulation-making powers. However, it expressed concerns about the costs of student registration to students and training providers, and the administrative difficulties of ensuring that the register is accurate. It concluded:

> This is an area that we intend to explore further. However, we would note at this point that it is possible that the General Optical Council may not seek to have compulsory student registration powers activated by the Government under a new statutory framework.

5.33 The Institute of Biomedical Science argued that:

> A more proportionate approach would be for the regulators to only approve education providers whose courses leading to registration teach the principles and practices of professionalism and the expectations of a healthcare professional.

5.34 A small number opposed the proposal on the basis that decisions relating to the introduction of student registers should not be a matter for Government. For example, the Nursing and Midwifery Council argued that the regulators should be left to decide whether or not to introduce a student register or whether an alternative is proportionate and effective.

5.35 The Department of Health, Social Services and Public Safety for Northern Ireland felt that the proposal needed "further consideration in the context that the universities/colleges have responsibilities for vetting students".

Question 5-5: Should student registration be retained in the new legal framework, and/or how can the legal framework help to ensure that the principles and practices of professionalism are embedded in pre-registration training?

5.36 A majority felt that student registration should be retained in the new legal framework.[6] For example, the Academy of Medical Royal Colleges stated that:

> Students should be encouraged to develop a professional ethic from the start of their studies. A student register could be introduced by the regulators and guidelines produced on the criteria for admission or removal from this register.

5.37 The Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies at South Staffordshire and Shropshire Health Care NHS Foundation Trust reported that "resolving issues through working with the University and the Trust to deal with fitness to practise issues can sometimes be difficult". It was thought that student registration would provide "an additional sanction tool".

[6] Of the 192 submissions which were received, 57 expressed a view on this question: 35 said student registration should be retained, 19 disagreed and 3 held equivocal positions.

5.38 Several consultees supported the registration of social work students. The British Association of Social Workers argued that social work students need to be registered for reasons of public protection because they often work "without direct supervision with some of the most vulnerable people". The College of Social Work argued that the arguments for registration of student social workers were much stronger than for health professionals "where there is limited contact with patients and service users". An individual consultee (Don Brand) suggested that the Health and Care Professions Council's decision not to register student social workers was "a worrying instance where the regulator has not taken account of the different learning processes of the different professions it regulates, and has chosen uniformity over effectiveness".

5.39 The Care Council for Wales and the Northern Ireland Social Care Council suggested there is evidence that, in relation to student social workers, "the requirement to meet the registration thresholds has sharpened the recruitment and selection of the universities". It has also been found that students are "much more conscious of their professional role through being registered with the regulatory body from the point of entering professional training". They also argued there is an economic benefit to "weeding out, as far as possible, those who are unsuitable at the start of the training rather than the cost to the public purse of training people who are not suitable".

5.40 The Medical Protection Society argued that "where students have contact with the public as part of their training, registration would be appropriate" but student fitness to practise hearings should remain under the remit of the educational establishments. It also suggested that the regulators could have "advisory oversight" of the processes and the possibility of a representative member of a fitness to practise panel on student panels.

5.41 However, a number of consultees were opposed to student registers. For example, the Medical Defence Union stated that:

> It would not simply be a matter of registering students. The regulator would need to set up new procedures to deal with matters such as application and approval processes and removal from the register etc. There would be numerous other considerations, for example, whether students should be subject to the regulator's "fitness to practise" proceedings and how this would fit in with their school and university's own procedures. All this additional activity would incur considerable expense which would presumably be funded principally, if not entirely, by registrants because students do not have sufficient financial means.

5.42 Similarly, the Optometry Course Team at the University of Ulster argued that student registration should not be retained because it is "disproportionate, unnecessarily bureaucratic and hinders dealing with issues in a timely fashion". The Committee of Contact Lens Educators agreed that student registration "is unnecessary and burdensome".

5.43 The British Association and College of Occupational Therapists thought that the introduction of student registration would "duplicate activity and detract from the

greater priority of developing students' understanding of professional responsibilities".

5.44 The Professional Standards Authority argued that risks associated with "poor performance, harm to service users, fraudulent re-enrolment and programme hopping" should be managed through:

> the design and delivery of courses, including robust recruitment practices, clear admission criteria, embedding professionalism and standards of conduct throughout the course, and effective supervision. The regulator has a role supporting education providers, through advice and guidance on standards to be met and the management of fitness to practise issues among students.

5.45 Some opposed student registration because students are at a different stage of their development compared to registrants. For example, the Society of Chiropodists and Podiatrists stated that:

> Students must have the freedom to learn, both how to be a competent clinician and how to behave professionally. It would be tragic if a student's future career were destroyed as the result of a youthful mistake or misjudgement.

Embedding professionalism in pre-registration training

5.46 A number of consultees expressed a view on how the legal framework could help to ensure that the principles and practices of professionalism are embedded in pre-registration training. Of those, a small majority said that professionalism should be promoted through curricula.[7]

5.47 The British Medical Association pointed out that, in order to strengthen engagement with students, the General Medical Council plans to issue its reference numbers at the beginning of the final year of student courses, rather than towards the end of their final year.

5.48 The Medical Schools Council felt that the statute should "encourage regulators to work with education providers to develop mechanisms for identifying, reporting and sharing information relating to fitness to practise incidents".

Other comments

5.49 The Northern Ireland Practice and Education Council for Nursing and Midwifery supported compulsory student indexing as there is no mechanism in Northern Ireland to enable higher education institutions to alert the regulatory body "should there be an issue in relation to a student's fitness to practice". Thus, a student may be removed from a course but then "embark on another course at a different higher education institution or get a job in a caring role without disclosure of their

[7] Of the 192 submissions which were received, 31 expressed a view on this question: 18 said that professionalism should be promoted through curricula, 7 said that the regulators should work with the educational institutions, 4 said that student registration would itself lead to professionalism being embedded and 2 said that there was no need to alter legal framework in this context.

fitness to practice issues". It was argued that indexing "would enable that tracking of students and thus enhance public protection". The Royal College of Midwives suggested that the Professional Standards Authority could be required to maintain "a register of all students to prevent individuals disciplined and removed from one health professional training programme, joining another".

5.50 The College of Optometrists argued that a distinction must be made between undergraduate registration and the provisional registration of pre-registration professionals. In the case of pre-registration optometrists, the College argued that provisional registration is essential since "although they practise under supervision, and the supervisor must be in the same building, pre-registration optometrists often work alone with patients". The General Optical Council also considered that regulators should retain the power to register students on a provisional registration basis, as well as a system of registration of all students. It also pointed to differences in the way that training is structured for the professions that it regulates and the levels of unsupervised practice.

Question 5-6: Should the regulators be given powers to introduce voluntary registers?

5.51 Opinion was divided on this question. Exactly fifty per cent of consultees agreed that the regulators should be given powers to introduce voluntary registers, but a significant number disagreed.[8]

5.52 The UK Public Health Register, which maintains a voluntary register for public health practitioners, put forward the case for voluntary registers. It felt that:

> The benefits of a voluntary register … are that it establishes a clear boundary around a defined professional group where an assessment of public risk has shown insufficient reason to move directly to statutory registration; provides a readily accessible statement of the values and ethics to which members of that group subscribe; constitutes a powerful means of exerting effective peer pressure on professionals both to demonstrate current competence and to answer formal complaints; and furnishes employers and the public with a means of handling questions about the fitness of an individual to retain the quality mark of registration.

5.53 The Department of Health strongly supported voluntary registers. It stated that:

> Voluntary registers of professionals have existed for many years and have successfully helped to set standards and expectations for a range of professions and occupational groups. For some groups of workers no involvement of an external organisation is needed to establish a voluntary register, as effective professional and occupational networks already exist within which it is possible for the conditions to support the establishment of a voluntary register to develop organically. However, this is not the case for all groups of

[8] Of the 192 submissions which were received, 76 expressed a view on this question: 38 said that the regulators should be given such a power, 30 disagreed, whilst 8 held equivocal positions.

> workers and in some cases, particularly for lower paid workers in supporting roles, voluntary arrangements are less likely to be fostered by the workers themselves. In these circumstances it is our view that the skills and expertise of existing regulatory bodies could be used to help establish voluntary registers and standards for those groups. The use of the existing infrastructure within the regulatory bodies, coupled with the higher numbers of statutory and voluntary registrants will allow the regulators to operate a voluntary register at reduced costs, compared with some other bodies.

5.54 The Association for Nutrition, which maintains a voluntary register for nutritionists, argued that the effects of its register "are equal to that of a statutory register; although without the consequent protection of title or function". This is partly due to the fact that registered nutritionists are subject to a Code of Ethics and Professional Conduct.

5.55 The Health and Care Professions Council was also in favour of retaining the powers to establish voluntary registers, arguing that such registers:

> have the potential to contribute to public protection, particularly where for a given group a voluntary register does not already exist and where arrangements can be put in place to encourage or compel registration.

5.56 Many of those who supported voluntary registers did so because they were seen as an interim measure leading to statutory registration. For example, the Pharmaceutical Society of Northern Ireland regarded voluntary registers as a "valuable precursor to statutory registers" and supported the notion that "voluntary registers should be a matter for regulators to decide based upon their assessment of risk". Similarly, Unite only supported voluntary registers where "this is part of the preparation for a profession to become registered". The Department of Health, Social Services and Public Safety for Northern Ireland's support for the proposal was also on the condition that the establishment of voluntary registers was limited to cases where there was a "clear intention to form a statutory register".

5.57 The Optical Confederation supported a power for the regulators to introduce voluntary registers provided "there was a right of appeal to the Health Departments against this by the professions already regulated" in order to:

> prevent the risks of regulation creep, of regulators seeking to bring new groups into regulation to boost funding and of the potential undermining of the professional status of existing registered professionals.

5.58 It also argued for further limits on the powers granted to the regulators, in particular a stipulation that "voluntary registers should operate on a full cost recovery basis" to ensure that registrants are not funding the voluntary register.

5.59 However, the Professional Standards Authority disagreed that the regulators should have powers to introduce voluntary registers. It felt that voluntary registration should be clearly distinguished from statutory regulation "to avoid

confusing the public and undermining the validity of either model". It further argued that:

> The personal behaviours that drive a professional group to self-organise – a commitment to achieve higher standards – are unlikely to exist amongst groups that are "hosted" by a statutory regulator … This need not preclude statutory regulators from offering services to voluntary registers on a commercial basis, for instance managing a register on their behalf, but the two systems must remain visibly and distinctly separate.

5.60 The General Optical Council, along with several other consultees, was also wary of the potential for confusion. The Council suggested that alternative wording might be helpful in that regard, and suggested that "lists" would be more appropriate.

5.61 The Institute of Physics and Engineering in Medicine was opposed to voluntary registers, which it described as "divisive and confusing". It felt that a workforce "either required regulation or not", a view shared by the Association of Clinical Biochemistry.

5.62 The General Medical Council was also opposed to voluntary registers. It said:

> We do not see the value of voluntary registers being held by professional regulators. A professional group either merits formal regulation or it does not. By undertaking both statutory and voluntary regulation a regulator risks confusing the public and undermining the credibility of both models. Furthermore, if the paramount objective of regulators is to protect the public and ensure public confidence it is difficult to see how this can be achieved when those who may pose the greatest risk to the public would have the choice over whether or not they wished to be regulated.

5.63 The Patients Association expressed "deep and grave concerns" about the use of voluntary registers and argued "that their use is a danger to patients where the status of the list and indeed the registrants on said list is in doubt". The Royal Pharmaceutical Society of Great Britain felt that there was "little value in a register that is non-mandatory and fails to offer a safeguard to the profession that mandatory regulation applies". The Society, therefore, considered the introduction of voluntary registers to be a "retrograde [step] in the modernisation of professional regulation".

5.64 Pharmacy Voice thought that voluntary registers could create a two tier system as it would leave "the most vulnerable people likely to use the staff not on the register and the staff who know they are not up to standard would not be likely to register".

5.65 The Nursing and Midwifery Council argued that there is "not yet a body of evidence to inform opinion on the public protection benefit of voluntary registers". It suggested "there is now an urgent need to begin development of an evidence base around this approach to public safeguarding". UNISON also called for the further testing of the new powers under the Health and Social Care Act 2012 before any conclusions are reached about voluntary registers. The Scottish

Government suggested that the question of voluntary registers should be "revisited at regular intervals" to ensure that any learning from the Professional Standards Authority's implementation work is reflected in the review.

5.66 The Rehabilitation Engineering Services Management Group said that the consultation paper made:

> no attempt to explain the relative merits or fundamental differences between mandatory and voluntary systems of registration save that it reminds us that protected titles and functions relating to mandatory registration may be enforced under the criminal law.

Question 5-7: If the regulators are given powers to introduce voluntary registers, should the Professional Standards Authority be given a formal power to recommend to the regulator in question that a group should become or cease to be voluntarily registered? If the regulator decided not to comply, it would be required to issue a report setting out its reasons.

5.67 Opinion was divided on this question. Fifty percent of consultees agreed that the Authority should be given such powers but a significant number disagreed.[9]

5.68 The British Psychological Society supported a formal power since this "would provide an accountable framework and safeguard the public". An individual consultee (Jacqueline A. Wier) agreed that oversight was necessary to "ensure that regulation is robust." The Joint Committee on Genetic Counselling Regulation also supported a role for the Professional Standards Authority.

5.69 The Health and Care Professions Council suggested that such a power was unnecessary because it would conflict with the Authority's function of quality assuring and accrediting voluntary registers. It was also argued that the Authority already has powers to make recommendations for actions and improvements in its annual performance review which could cover voluntary registers. The General Dental Council also felt that such a power was unnecessary because the Authority would automatically be consulted on any proposals to establish or remove a voluntary register. The General Chiropractic Council expected that the Authority would be likely to issue recommendations, and so the Council agreed that there was no need for a formal power.

5.70 The Nursing and Midwifery Council was "cautious" about giving the Professional Standards Authority this power because:

> It appears to compromise the independence of the regulator and the right of decision-making bodies to set strategy in accordance with their statutory purpose. This renders regulators independent in letter but not in spirit, and we believe the public interest is best served by independence, coupled with effective governance and accountability.

[9] Of the 192 submissions which were received, 40 submissions expressed a view on this question: 20 agreed that the Professional Standards Authority should be given such a power, 17 disagreed, whilst 3 held equivocal positions.

5.71 The Professional Standards Authority itself also disagreed that it should be given a formal power because "this would cut across the powers vested in us by the Health and Social Care Act 2012 to independently accredit organisations to open voluntary registers". The Department of Health also thought the proposed power was unnecessary "as this can be dealt with under other powers and duties in relation to monitoring performance of regulators and voluntary registers". Similarly, the Scottish Government disagreed that the Authority should be given powers to make recommendations "as powers/duties already exist in this regard under the existing monitoring arrangements of the regulators".

Question 5-8: Should non-practising registers be retained or abolished?

5.72 A slim majority felt that non-practising registers should be abolished.[10] For example, the Health and Care Professions Council argued that:

> Registration exists to protect the public and it is important that registers are a reflection of those professionals who continue to meet the regulators' standards. An individual who remains registered with any of the regulators should continue to meet the relevant standards for practice including meeting any continuing professional development requirements.

5.73 The Dental Schools Council argued that non-practising registers "add to confusion" and "do not reflect an individual's appropriate competence, fitness to practise or ongoing continuing professional development", and therefore, they do not "enhance or add to public safety". Similarly, the Chartered Society of Physiotherapy argued that non-practising registers "undermine clarity and public/employer understanding and [are] cumbersome to administer".

5.74 The Department of Health considered that "there is scope for considerable confusion about the purpose of non-practising registers" but added that "removing the non-registered (or unlicensed) part of the register may cause a number of operational difficulties for the General Medical Council".

5.75 The Scottish Government argued that there was "much confusion" regarding non-practising registers and that the statute should clarify what is meant by the term "non-practising". On balance, it felt that such registers should only be retained for those "who perform management, education or advisory roles which directly or indirectly impact upon patient care". Such individuals need to be up to date "in their knowledge-base and demonstrate that they have satisfactorily met their ongoing professional requirements".

5.76 The Patients Association argued that:

> The function of non-practising registers in keeping professionals in touch with their profession is well enough served by the professional bodies and Royal Colleges which will attract more prestige and recognition than registration with a regulator. Naturally, if non-

[10] Of the 192 submissions which were received, 62 expressed a view on this question: 19 said that non-practising registers should be retained, 35 said that non-practising registers should be abolished, whilst 8 held equivocal positions.

> practising professionals wish to return to practise, they may do so but they must be able to show that they are fit to practise before being re-entered onto the register.

5.77 The Professional Standards Authority described non-practising registers as "a relic of professional self-regulation" and "only benefiting registrants who wish to retain their 'status' as professionals beyond their practising careers". The British Association for Counselling and Psychotherapy agreed that non-practising registers should be abolished as "the main purpose of a register is to protect the public, not enhance the status of individual registrants".

5.78 The General Medical Council retains a system whereby a doctor can be registered but not licensed to practise. The Council felt that the system only has value in particular circumstances. These include where doctors practise overseas in jurisdictions which look to the Council "for assurance of the individual's adherence to the values of the profession", or when a doctor is performing "non clinical roles which nevertheless draw on their training and experience as a doctor". It concluded:

> We see no value in registering and regulating individuals who no longer have any involvement in activities, whether clinical or non-clinical, connected with the practise of the profession.

5.79 The Department of Health, Social Services and Public Safety for Northern Ireland argued that non-practising registers should be abolished since "a non-practising register seems self contradictory".

5.80 However, a number of consultees supported the retention of non-practising registers. The Academy of Medical Royal Colleges suggested that such registers "serve an important purpose for doctors in particular who may need to re-enter practice later". The Royal College of General Practitioners suggested that non-practising registers provide a public benefit by allowing doctors return to practice "without additional impediment".

5.81 The Society of Chiropodists and Podiatrists argued that:

> Registrants spend many years building up their status as professionals and define themselves according to their chosen profession. It seems callous and unnecessary to take away this status and pride, providing that regulators demarcate clearly between practising and non-practising.

5.82 Optometry Scotland supported the retention of non-practising registers "as this ensures all professionals are bound by the codes of conduct and less likely to bring the profession into disrepute".

5.83 The Institute of Health Visiting Professionals pointed out that:

> The list held by the Nursing and Midwifery Council of formerly qualified health visitors who are no longer practicing was recently used by Department of Health as part of the recruitment exercise – to invite such individuals to consider applying for return to practice

> programmes and revalidate their qualification. So, this is potentially useful – and should be retained.

5.84 The Medical Defence Union rejected the argument that non-practising registers undermine public safety because, in the case of doctors, such registrants do not hold themselves out as licensed practitioners.

5.85 The Association of Regulatory and Disciplinary Lawyers considered that a non-practising register:

> bestows an acceptable status on former practitioners, but more importantly provides a clear delineation in the public's mind between non-practising practitioners and those whose name has been erased or removed from the register following fitness to practise proceedings.

5.86 The General Osteopathic Council – which maintains a category of non-practising status on its register – wished to maintain this system, along with "the ability to make rules to test competence before restoration to the 'practising register'". It also felt that the definition of non-practising was unclear.

Provisional Proposal 5-9: The regulators will be required to register applicants on a full, conditional or temporary basis. In addition, the regulators will be given powers to introduce provisional registration if they wish to do so.

5.87 An overwhelming majority agreed that the regulators should be required to register applicants on a full, conditional or temporary basis.[11] For example, the Professional Standards Authority felt that this proposal would ensure greater consistency across the regulators in relation to the types of registration that are available to all the regulators. An individual consultee (Jane C Hern) felt that "full, conditional and temporary classifications are similarly helpful to accommodate a variety of circumstances, including emergency needs".

5.88 The Nursing and Midwifery Council agreed that regulators should be able to establish different types of registration, but only if to do satisfied "a public protection and proportionality test".

5.89 However, some consultees raised concerns about conditional registration. The General Medical Council pointed out that its general system of conditional registration (in non fitness to practise cases) – which imposed certain conditions on the practice of international medical graduates – was abolished in 2007. The Council considered that any move towards restoring it would be a "retrograde step". It argued that when registration is granted "it is in the public interest that the new registrant should be fit to practise, not partially fit to practise". The Council also felt there may be major implications for education and training leading to registration, since some applicants will not need to have completed the full programme of education and training normally required.

[11] Of the 192 submissions which were received, 36 submissions expressed a view on this proposal: 33 agreed, whilst 3 disagreed.

5.90 The Association of Regulatory and Disciplinary Lawyers was also concerned about conditional registration outside of fitness to practise cases. It pointed out that both the General Chiropractic Council and the General Osteopathic Council retain powers to grant conditional registration. These were only used when the registers were initially set up to allow experienced practitioners who did not hold a recognised qualification to be "grandfathered" onto the new statutory registers. This power has since remained dormant.

5.91 The General Osteopathic Council did not support conditional registration. It felt that "it is important for transparency and public protection that all registrants are fit to practise at the point of registration". The Council also argued that "conditions of practice should be a matter to be determined by a Fitness to Practise Panel rather than as a function of the registration process". However, the General Optical Council considered that there are circumstances in which it would be "valuable" to impose conditions at the point of registration, although it did not envisage this power being used regularly.

5.92 A small number of consultees opposed this proposal. For example, UNISON disagreed with different registration levels and argued that it must be "clear and unambiguous" that registrants are "registered and fit to practise or they are not".

Provisional registration

5.93 A majority agreed that the regulators should be given powers to introduce provisional registration if they wish to do so.[12]

5.94 The Health and Care Professions Council agreed with the proposal but stated it would be unlikely to use any such powers due to the financial and other costs. The British Association for Counselling and Psychotherapy felt that provisional registration should be "the exception where newly qualified professionals require further experience to become full registrants" rather than being used to "provisionally register those who do not meet standards".

5.95 The Department of Health's view on the use of provisional registration was:

> We consider that for some professions it makes sense for provisional registration to apply where a professional has completed an undergraduate degree, but is then required to complete a year of practical training under the supervision of a university before being registered. We would distinguish the situation, where a person has the necessary knowledge and theory to practise their profession, but needs to gain experience of applying that theory before they can be deemed "fit to practise" without supervision, from student registration where a person has not yet acquired the knowledge and skills to practise their profession.

5.96 The Association of Regulatory and Disciplinary Lawyers argued that provisional registration was "confusing to the public" and that, generally, "registration should indicate that the registrant is fully fit to practise without

[12] Of the 192 submissions which were received, 39 expressed a view on this proposal: 27 agreed, 10 disagreed, whilst 2 held equivocal positions.

restriction" (except in fitness to practise cases). The Society and College of Radiographers believed that provisional registration would be "ambiguous and unhelpful" from the perspective of the public and registrants.

5.97 Several consultees linked provisional registration with student registration. For example, the General Optical Council saw provisional registration as a possible alternative to a full, compulsory student registration scheme.

5.98 The Department of Health, Social Services and Public Safety for Northern Ireland disagreed "with the principle of provisional regulation [for nurses] beyond what is identified for doctors".

Provisional Proposal 5-10: The statute will provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.

5.99 An overwhelming majority agreed that the statute should provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.[13]

5.100 The Medical Defence Union felt that the potential benefits of this proposal were demonstrated by "the arrangements that were made by the General Medical Council in anticipation of the flu pandemic". The Association of Clinical Biochemistry suggested that there should be a requirement that any such changes to the register should be regularly reviewed. Other consultees, such as the General Dental Council, pointed to the need to consider devolution issues especially since emergencies, such as a pandemic, may be limited to one of the devolved countries.

5.101 The National Clinical Assessment Service was amongst several consultees who sought greater clarity about the definition and timescales for registration. The Nursing and Midwifery Council suggested that the statute should define the changes that can be made and the meaning of emergency. The Council suggested the latter should be "an event or situation which threatens serious damage to human welfare in the UK", as provided for in its governing legislation. The Professional Forum of the Pharmaceutical Society of Northern Ireland suggested that "temporary" should be defined as being "six months but renewable thereafter".

5.102 The Department of Health pointed out that the emergency powers were introduced to cover emergencies "such as pandemics and were designed to ensure supply of drugs, medicines and appliances". It therefore argued that emergency registration does not need to apply to all professions, "for example, psychologists, chiropodists [and] podiatrists". Therefore, the Secretary of State should be able to "state the regulatory bodies to which the emergency powers would apply" and "restrict the application of emergency powers by a regulator to only some of the professions they oversee".

5.103 The Scottish Government argued that:

[13] Of the 192 submissions which were received, 39 expressed a view on this proposal: 38 agreed, whilst 1 held an equivocal position.

> The Secretary of State should also specify the regulatory bodies and professional/healthcare groups to which the emergency powers would apply, the intended duration of these powers, and the particular circumstances in which they apply.

5.104 It also stated that such powers "pertained to some professional groups more than others" and that "powers could apply in a wider range of situations than pandemics and that the statute needs to provide for these".

Provisional Proposal 5-11: The statute should specify that in order to be registered on a full or temporary basis the applicant must be appropriately qualified, be fit to practise, have adequate insurance or indemnity arrangements (except for social workers), and have paid a prescribed fee. The regulators should have broad rule-making powers to specify the precise detail under each of these requirements.

5.105 An overwhelming majority agreed that in order to be registered on a full or temporary basis an applicant must be appropriately qualified, be fit to practise, have adequate indemnity/insurance and have paid a prescribed fee (and that the regulators should have broad powers to make rules under each of these headings).[14]

5.106 The Department of Health supported the proposed criteria for full and temporary registration. It felt that "the regulators should also be specifically required to ensure that any such rules are compliant with EU Directive 2005/36/EC in this area".

5.107 Many also argued that the detail of the rules should be consistent across the regulators. The Association of Regulatory and Disciplinary Lawyers suggested that such consistency was particularly important in relation to any health and character requirements, and requiring appropriate insurance or indemnity arrangements. The Scottish Government argued that the statute should seek to ensure "the requisite degree of transparency and accountability … and that a consistent approach is taken across all the regulators". However, the Professional Standards Authority felt that the detail is "likely to need to vary legitimately across the professions".

5.108 The General Medical Council agreed with the proposal on the understanding that "appropriately qualified" and "fit to practise" encompass:

> the possession of any necessary formal qualifications and appropriate knowledge, skills (including language proficiency) and experience, as well as the absence of any matters which might lead to a referral into our fitness to practise procedures. Care will also be needed in the drafting of the legislation to clarify that applicants must demonstrate fitness to practise at the point of registration as distinct from the absence of a finding that their fitness to practise is impaired.

5.109 The Professional Standards Authority welcomed the inclusion of a generic fitness to practise requirement that encompasses both health and character. It said that:

[14] Of the 192 submissions which were received, 46 expressed a view on this proposal: 45 agreed, whilst 1 held an equivocal position.

> The regulators' current requirements in relation to health in particular are relatively blunt and can lead to discrimination. The principles of right-touch regulation suggest that at the point of registration and renewal, a self-declaration approach to health or character issues that could impair fitness to practise (followed by enquiries where there appears to be a risk) is a targeted and proportionate regulatory measure; and that employers are better equipped than the regulator to make decisions relating to health or character *in situ*.[15]

5.110 The Nursing and Midwifery Council and Royal College of Midwives suggested that being "fit to practise" should be defined to include "the concept of the applicant being of good standing, as well as having the capability to be a safe and effective practitioner".

Indemnity and insurance

5.111 A number of consultees commented expressly on the proposed criterion relating to indemnity and insurance. A majority agreed with the criterion.[16] For example, Pharmacy Voice felt that "patients should have the reassurance of knowing that, in the event of something going wrong, professionals are appropriately insured".

5.112 However, the British Association of Dental Nurses argued that "adequate" should be clearly defined. It said that "registrants should be required to have their own indemnity cover – preferably insurance as that is regulated in contrast to other forms of indemnity cover".

5.113 The Nursing and Midwifery Council felt that the regulators are limited in their ability to determine the adequacy of insurance arrangements. It suggested – in line with the recommendations of the *Scott report* – that the applicant must have "insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered health care professional" rather than "must have adequate insurance".[17]

5.114 The Medical Protection Society suggested the following definition of indemnity arrangements:

(1) a policy of insurance;

(2) an arrangement made for the purposes of indemnifying a person; or

(3) a combination of a policy of insurance and an arrangement made for the purposes of indemnifying a person.[18]

5.115 Some consultees also suggested that our proposal could go further. For example, Action Against Medical Accidents argued that:

[15] Emphasis in the original.

[16] Of the 192 submissions which were received, 17 specifically addressed the criterion: 12 agreed with the criterion, whilst 5 disagreed.

[17] F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010).

[18] Reflecting section 44C of the Medical Act 1983 (Amendment) and Miscellaneous Amendments Order 2006.

> If a registered health professional causes harm to a patient and is found not to have sufficient indemnity, the regulator should be required to compensate the patient. It is unacceptable that a patient injured by a registered health professional should not be able to receive redress. Regulators should take responsibility for ensuring this does not happen.

5.116 Bridge the Gap suggested that the statute should impose additional duties in respect of insurance and indemnity arrangements, as it identified several problems with the regulators being responsible for setting and monitoring such arrangements. It said:

> We submit, therefore, that the duty to inform a patient of insurance or indemnity cover, like the duty to inform of treatment options and safety, is that of the individual healthcare professional, and not that of the regulators, and this should be enshrined in statute as an individual healthcare provider's duty.

5.117 It also suggested:

> The Commissions should propose a requirement within the proposed legal framework that all healthcare professional liability insurers and indemnity providers have an overriding duty to cooperate with patients and patient representatives in enabling remedies to harm sustained.

5.118 The Nursing and Midwifery Council and the Medical Protection Society expressed support for the final recommendations of the *Scott report.* These were that the regulators should have powers to:

(1) require information in relation to cover;

(2) require registrants to inform the regulator if cover ceases;

(3) refuse registration if sufficient information about cover is not provided; and

(4) refer cases concerning inadequate or inappropriate cover to a Fitness to Practise Panel.[19]

5.119 The Medical Protection Society further proposed that the following reforms should be introduced in relation to personal cover required for self-employed practitioners:

(1) a duty on registrants to provide full disclosure of relevant facts to their insurer or indemnifier;

(2) registrants can rely on the defence that they have acted in accordance with the proposals of their insurer or indemnifier;

[19] F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010) p 4.

(3) if registrants wish to change the scope of their practice, they should first have, or acquire, adequate and appropriate insurance or indemnity; and

(4) regulators should consider their requirements for run-off cover and how to deal with past periods when the statutory condition of registration had been breached.[20]

5.120 Several groups – including the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group and the Association for Improvements in the Maternity Services – pointed to difficulties that the indemnity requirement could create for independent midwives who are not covered by existing professional indemnity schemes. Similarly, the Professional Standards Authority argued that the Government must "support the development of schemes to enable independent midwives to meet this requirement, if it were introduced". An individual consultee (Andrew Cottington) cautioned against a situation whereby the cost of insurance and other registration fees could mean that individuals were forced to stop practising.

5.121 West Sussex County Council felt that social workers should also be required to provide details of insurance or indemnity arrangements given the specialist roles that some undertake, and for which evidence of insurance and indemnity arrangements is a pre-requisite for practice.

Provisional Proposal 5-12: The regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.

5.122 An overwhelming majority supported the proposal that the regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.[21]

5.123 The British Pharmaceutical Students' Association thought that "formal public consultation" would be necessary in the regulators' exercise of the power to establish separate criteria.

5.124 The Professional Standards Authority argued that the statute must enable the regulators "to develop their renewal procedures to provide greater assurances than at present about a registrant's continuing fitness to practise". The Local Supervising Authority Midwifery Officers Forum UK also agreed with this proposal "assuming 'provisional to full' means moving from student to registrant".

Question 5-13: Should the statute provide that in order to be registered an applicant must demonstrate that they are a "fit and proper person" to exercise the responsibilities of their profession?

5.125 A slim majority agreed that the statute should provide that in order to be registered an applicant must demonstrate that they are a "fit and proper person"

[20] F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010).

[21] Of the 192 submissions which were received, 41 expressed a view: 40 agreed, whilst 1 disagreed.

to exercise the responsibilities of their profession.[22] For example, the British Psychological Society supported the proposal, which it considered "a positive criterion that puts the onus on the individual to demonstrate the qualities required".

5.126 The Nursing and Midwifery Council said that it would welcome the ability for regulators "to set their own requirements below that of 'fit and proper person' and define what constitutes a fit and proper person, in the context of their own professions". The Royal College of Midwives argued that "the public has the right to assurances that those in whom they place their trust are 'fit and proper'". The Northern Ireland Practice and Education Council for Nursing and Midwifery also supported this criterion, arguing that "fitness to practice alone does not automatically imply good character, something which is at the heart of the caring profession and should apply to all regulators".

5.127 The Scottish Government argued that a general requirement to be a "fit and proper person" and to demonstrate good character should be contained in the statute "as these directly relate to a professional's fitness to practise". However, it opposed any suggestion that the regulators should establish in rules any additional criteria to determine whether professionals are "fit and proper" as this could have the effect of "creating double standards and suggests that the public require a greater degree of 'protection' from some groups rather than others".

5.128 Some consultees, for example the Local Supervising Authority Midwifery Officers Forum UK and the Medical Protection Society, were of the view that the proposal would only be effective if the concept of "fit and proper person" was clearly defined.

5.129 However, some were concerned that the term "fit and proper" was too subjective and would lead to inconsistency. For example, the Medical Defence Union stated:

> While it is reasonable to expect a regulator to assess measurable and relevant competencies which can be easily defined, we do not think it reasonable to expect a regulator to determine if a person is "fit and proper". Further, with no clear objective measures, it would be more difficult to achieve consistency in decision-making which may make assessments more vulnerable to challenge.

5.130 The Association of Clinical Biochemistry anticipated "considerable difficulties in applying an appropriate legal test to establish whether an individual is a 'fit and proper person'". South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) agreed that the concept appeared "somewhat meaningless and open to numerous interpretations".

5.131 The General Social Care Council and UNISON argued that the term might be interpreted by some regulators as excluding anyone with a conviction from the profession, or in a way that is incompatible with the Equality Act 2010.

[22] Of the 192 submissions which were received, 56 expressed a view on this question: 31 said that the statute should so provide, 18 disagreed, whilst 7 held equivocal positions.

5.132 Several consultees argued that this criterion is unnecessary given that applicants would be required to be fit to practise. For example, the Professional Standards Authority felt that the regulators should only have the "freedom to require that registrants be of good character to the extent that it relates to their fitness to practise". Similarly, the General Medical Council felt that "the terminology also seems to refer back to the anachronistic concept 'good character' which we have discarded in favour of 'fitness to practise'".

5.133 The Department of Health argued that the statute should require that, in order to be registered, a person must be fit to practise their profession and that "regulators should be free to determine whether the applicant should demonstrate that they are a fit and proper person".

5.134 A number of consultees, such as the General Dental Council, pointed out that "fit and proper" is widely used in the context of company law and regulation and, therefore, might be a suitable requirement in the context of entity regulation.

Question 5-14: Should the legislation state that applicants are entitled to be registered provided that they satisfy the relevant criteria or that the regulator must register the applicant provided that they satisfy the relevant criteria? Does either formulation make any difference in practice?

5.135 Opinion was divided over whether the legislation should state that applicants are "entitled" to be registered or that the regulator "must register" the applicant provided that they satisfy the relevant criteria.[23]

5.136 The General Dental Council felt "that the current formulation 'entitled' works satisfactorily, and there is no compelling case to change it". In contrast, the Professional Standards Authority felt the second formulation "embodies the spirit of modern professional regulation". The Institute of Health Visiting agreed that the requirement to register was "more consistent with the paramount duty to protect the public".

5.137 The General Osteopathic Council argued that this issue went beyond symbolism. It said that the important point is that the regulator must be "satisfied that the applicant meets the criteria at the point of first registration". The regulator must have "the ability to explore and test the applicant's fitness to practise at the point of registration and may refuse an application" (whereas in contrast renewal can be on an administrative basis).

5.138 Pharmacy Voice also supported the first formulation, on the basis that it was necessary to ensure that the regulator has "the option of refusing to register an applicant if, for example, an applicant has a character failing which would make them unsuitable to work as a pharmacist".

5.139 The Scottish Government also suggested that the word "entitled" should be dropped given that registration "is dependent on a number of relevant criteria being satisfied", particularly good character, "rather than an entitlement (for

[23] Of the 192 submissions which were received, 40 expressed a view on this question: 11 preferred the first formulation, 15 preferred the second formulation, whilst 14 said that there was no difference in practice between the two formulations.

example, following the acquisition of a professional qualification)". It also pointed out that EU Directive 2005/36/EC is relevant in terms of automatic recognition of qualifications and it is important that any change to the wording is compliant with this Directive.

5.140 The Department of Health was amongst several consultees who considered that there was no practical difference between the formulations. The General Social Care Council could not discern a "significant amount of difference".

Provisional Proposal 5-15: The statute should require the regulators to communicate expeditiously with registrants and potential registrants. The regulators would be given broad rule-making powers concerning the processing of registration applications.

5.141 The vast majority agreed that the statute should require the regulators to communicate expeditiously.[24] All consultees who responded agreed that the regulators should be given broad rule-making powers concerning the processing of registration applications.[25]

5.142 The Department of Health agreed with both proposals. It also suggested that EU (European) law may "prescribe specific timeframes for processing certain types of applications and therefore the regulators should be under a general duty to observe these requirements".

5.143 The Professional Standards Authority argued that:

> The statute should allow regulators to extend their deadlines when processing an application if there is evidence of a risk to public protection. We would guard against any provisions for automatic registration or renewal where regulators fail to meet a deadline for application processing.

5.144 However, the General Chiropractic Council and the General Dental Council expressed concern about endless possibilities of legal action over the meaning of the word "expeditious". To address this, the General Dental Council suggested that the Professional Standards Authority could issue guidance and monitor compliance as part of its annual performance review.

5.145 A small number of consultees suggested that the statute should specify timescales for communications. The Scottish Government supported these proposals. It did recommend that the statute should set down "minimum procedural requirements in terms of the *broad* timescales in which regulators are required to respond" which take into account "modern methods of communication such as email and DX".[26]

[24] Of the 192 submissions which were received, 41 expressed a view on this proposal: 38 agreed, 2 disagreed, whilst 1 held an equivocal position.

[25] Of the 192 submissions which were received, 26 submissions expressed a view on this proposal: 26 agreed.

[26] Emphasis in the original.

Provisional Proposal 5-16: The statute should require each regulator to establish an appeals process for when registration applications are refused. The regulators would have broad powers to decide the precise process it wants to introduce.

5.146 An overwhelming majority agreed that the statute should require each regulator to establish a registration appeals process.[27] For example, the Professional Standards Authority pointed out that its *Standards of Good Regulation* stipulate that the "management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving".[28] In line with this, it argued:

> The statute should set out the regulators' duty to establish an appeals process, under which we would expect regulators to continue to meet our standards in this area.

5.147 However, some argued that the systems established by the regulators should be as consistent as possible. For example, the Association of Regulatory and Disciplinary Lawyers felt that "a registration appeals committee is a sensible and helpful way of dealing with appeals against refusal of registration and also provides transparency". NHS Education for Scotland agreed that a "consistent approach" was required.

5.148 An individual consultation response (Dr Waghorn and Dr Jooste) also suggested that the right of appeal should extend to cases where the regulator decides to register the applicant in a type of registration other than that applied for, or subject to a condition. The General Medical Council felt that the right to appeal should be circumscribed and should not exist "where the reason for refusal of the application is because the applicant did not possess an acceptable qualification".

5.149 Others argued that the statute should require the regulators to give reasons for the decision, supply the applicant with any documentation that had been used in order to reach the decision (such as medical reports), and provide details of how to lodge an appeal.

5.150 The General Osteopathic Council suggested that, in the same way that Council members are prohibited from fitness to practise panels, "so too is it inappropriate for them to hear registration appeals and that these processes also require a degree of independence". The Professional Standards Authority argued that the statute may need to stipulate that "appeals decisions should not be made by committees on which members of the regulator's Council may sit, nor by a registrant Registrar".

5.151 The Administrative Appeals Chamber of the Upper Tribunal argued there should be a right of appeal to the First-tier Tribunal "which would make it unnecessary to set up internal appeal panels for registration cases".

[27] Of the 192 submissions which were received, 41 expressed a view on this proposal: 40 agreed, whilst 1 held an equivocal position.

[28] Council for Healthcare and Regulatory Excellence, *The Performance Review Standards – Standards of good regulation* (2010), para 5.1, .

Provisional Proposal 5-17: The statute should provide a right of appeal when registration applications are refused, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

5.152 A significant majority agreed that the statute should provide a right to appeal to the higher courts.[29] For example, the College of Social Work argued that "there must be an appeal process independent of the regulator so that an aggrieved applicant can be confident that appeal decisions are impartial and fair".

5.153 The Scottish Government supported the proposals and agreed that the appropriate court in Scotland would be the Court of Session. However, it also considered that:

> There is a strong need for transparency and accountability in the process adopted to ensure fairness and consistency and to maintain confidence in the professions. We suggest that this is an area where the Professional Standards Authority could have a useful role to play in monitoring and scrutinising performance.

5.154 However, some expressed concern that this would be much more expensive than the current system (for some regulators) which allows for a right to appeal to the county court.

5.155 The Scottish Court Service also felt that the sheriff court would be the most appropriate level for a right of appeal, rather than the Court of Session:

> The sheriff courts have a wide ranging experience of appeals from Statutory Bodies and, as stated in the report, currently have jurisdiction for appeals under some of the existing legislation. In reaching this view, we have considered Lord Gill's Scottish Civil Courts Review, which recommends the effective and efficient use of the civil court's own resources, allocating them to cases in proportion to the importance and value of the issues at stake

Provisional Proposal 5-18: The regulators should have broad powers to establish rules concerning the upkeep and publication of the register.

5.156 All those who expressed a view agreed that the regulators should have broad powers to establish rules concerning the upkeep and publication of the register.[30]

5.157 The Nursing and Midwifery Council felt it was particularly important that each regulator should be given powers "to publish its register in such a manner as it considers appropriate". It said that "with [its] register having in excess of 650,000 registrants, electronic publication is the only viable option".

5.158 The Professional Standards Authority also argued that the public protection function of a register is such that "a duty (rather than a power) to *publish* it should

[29] Of the 192 submissions which were received, 40 expressed a view on this proposal: 34 agreed, 3 disagreed, whilst 3 held equivocal positions.

[30] Of the 192 submissions which were received, 41 expressed a view on this proposal: 41 agreed.

be included in the statute, along with a duty to keep it up-to-date".[31] The Association of Clinical Biochemistry agreed that "it should be clear that this is a duty of the regulators".

5.159 UNISON argued in support of consistency between the regulators "to ensure a level playing field". The Scottish Government felt that "there should be consistency in the content of the registers across the various regulators" and that they "should also be made available for inspection by members of the public at all reasonable times".

Provisional Proposal 5-19: The statute should require each regulator to establish a process for dealing with fraudulently procured or incorrectly made entries. The regulators would have broad powers to decide the precise process it wishes to introduce.

5.160 All those who expressed a view on the issue agreed that the regulators should be required to establish a process for dealing with fraudulently procured or incorrectly made entries, and be given broad discretion to decide which process to introduce.[32]

5.161 The Professional Standards Authority felt that the statute should permit the amendment of incorrect entries to the register without referral to a committee, where the mistake was the result of an administrative error. The General Medical Council felt it might be desirable "to be absolutely clear that [fraudulently procured] covers failure to disclose pertinent information". Many argued that the processes established by the regulators should be as consistent as possible.

5.162 The Administrative Appeals Chamber of the Upper Tribunal argued that regulators should be required to have processes for dealing with incorrectly made entries (based on the grounds of ignorance of, or a mistake as to, a material fact or legal or administrative error). However, it felt that this should not apply to fraudulently procured entries because such entries:

> will necessarily have been based on ignorance of, or a mistake as to, a material fact and the question whether there was fraud will, if it is necessary to go into it at all, be relevant to the question whether the would-be registrant is fit to practise and therefore as to what decision should be made on the review.

5.163 The Patients Association felt that, in the case of fraud or mistake:

> The result of an investigation into how this had occurred should also be made available to the public including any changes that may be introduced to internal procedures to prevent it from happening again.

5.164 The Nursing and Midwifery Council welcomed this opportunity to deal with these issues "as part of [its] registration function rather than within [its] fitness to practise procedures".

[31] Emphasis in the original.

[32] Of the 192 submissions which were received, 39 submissions expressed a view on this proposal: all agreed.

5.165 The Scottish Government argued that there should be a consistent approach to dealing with fraudulently procured entries "such as requiring all decisions to remove entries to be made by fitness to practise panels or the Registrar". It said that:

> Whilst we recognise that this could have resource implications, particularly for some of the smaller regulators, we consider that this would be in the public interest, would promote transparency and is in line with the overall aim of the review ie to simplify and make the legal framework more consistent (and maintain confidence in the professions).

Provisional Proposal 5-20: The statute should provide a right to appeal against registration decisions relating to fraudulently procured or incorrectly made entries, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

5.166 The vast majority agreed that there should be a right to appeal to the higher courts.[33] For example, the Nursing and Midwifery Council thought that it would be "beneficial for all appeals to go to the same level of Court jurisdiction".

5.167 However, some expressed concern about the costs of appeals to these courts. For example, the Administrative Appeals Chamber of the Upper Tribunal felt that this route was "disproportionate in terms of both cost and complication" and suggested an appeal to the First-tier Tribunal in the first instance. The Scottish Law Service also felt that the sheriff court would be the most appropriate level for a right of appeal, rather than the Court of Session.

Provisional Proposal 5-21: The statute should provide that applications for restoration in cases where a registrant's entry has been erased following fitness to practise proceedings must be referred to a Fitness to Practise Panel or similar committee.

5.168 An overwhelming majority agreed that applications for restoration from people who have been erased must be referred to a Fitness to Practise Panel.[34]

5.169 The Association of Regulatory and Disciplinary Lawyers suggested that "most if not all the regulators now follow this approach" and argued that:

> A robust process for consideration of applications for restoration is a critical element of the overall public protection ensured by the regulatory process and is one which has sometimes been a weak area in the past.

5.170 The Patients Association sought clarity on whether this process will apply "where a professional voluntarily erased themselves from the register, for example the doctor at the centre of the Baby P scandal". The Professional Forum of the

[33] Of the 192 submissions which were received, 39 submissions expressed a view on this proposal: 37 agreed, whilst 2 held equivocal positions.

[34] Of the 192 submissions which were received, 44 expressed a view on this proposal: 42 agreed, whilst 2 disagreed.

Pharmaceutical Society of Northern Ireland argued that if a registrant has been erased for failure to "complete or comply with continuing professional development requirements, then restoration must be via a continuing professional development committee". The National Clinical Assessment Service also thought there should be a practical element, and suggested "a performance assessment process".

5.171 Bupa Care Services agued for a requirement that the panel reviewing the application "must be one which has experience of the specific sector involved".

5.172 However, the General Dental Council disagreed with the proposal. It argued that "the regulators should be able to make their own decisions regarding the process for agreeing restoration" and did not accept "that it is necessary to provide for a particular process in the statute".

5.173 The Administrative Appeals Chamber of the Upper Tribunal argued that:

> An application for restoration to a register should be treated procedurally in the same way as an initial application for registration, albeit possibly by a different committee, and that this should be the same even if it follows erasure … There should be a right of appeal to the First-tier Tribunal against a refusal to restore to the register.

Provisional Proposal 5-22: The statute should provide a right to appeal against restoration decisions by a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

5.174 An overwhelming majority of consultees supported this proposal.[35] For example, the General Pharmaceutical Council agreed with "the proposal to move away from appeals to be made to the county courts or sheriff in Scotland".

5.175 The British Society of Hearing Aid Audiologists supported a right of appeal, but said that "it should not be to such a high authority … because most registrants could not afford the costs".

Question 5-23: Should the statute set a consistent time period before which applications for restoration cannot be made (in cases where a registrant's entry has been erased following fitness to practise proceedings), or should this matter be left to the regulators to determine?

5.176 A majority of respondents agreed that the statute should set a consistent time limit before which applications for restoration cannot be made.[36] For example, the Health and Care Professions Council felt that consistency was "crucially important for public protection and for public faith and confidence in the

[35] Of the 192 submissions which were received, 39 expressed a view on this proposal: 38 agreed, whilst 1 held an equivocal position.

[36] Of the 192 submissions which were received, 48 expressed a view on this question: 29 said that the statute set a consistent time period, 18 felt this matter should be left to the regulators to determine, whilst 1 held an equivocal position.

regulatory process". Similarly, the Society of Chiropodists and Podiatrists agreed that a set time period would benefit the public, as well as registrants.

5.177 The Association of Regulatory and Disciplinary Lawyers argued that there was no "logical justification for a different period to apply to different professions". The General Medical Council reported difficulties before it had introduced a five year time limit with people seeking restoration in inappropriate circumstances.

5.178 The Health and Care Professions Council and Nursing and Midwifery Council argued that restoration applications should not be made until a period of five years has lapsed since removal from the register, and that there must be a gap of 12 months between applications. The General Dental Council felt the period should be at least three years and preferably five years. The General Osteopathic Council considered that its current ten months limit is inadequate, although had no fixed view on the appropriate period.

5.179 The Department of Health considered that the statute should set a minimum length of time before an application for restoration can be made. The Department said that:

> We are unclear why a situation where there is significant variation between different bodies would be desirable, or necessary. This would also set a clear differential between erasure from the register and suspension.

5.180 The Department also suggested that the regulators should have the ability to stop someone from repeatedly making applications for restoration within a short space of time. The Scottish Government also argued that the regulators should be given powers to limit the number of times an application for restoration can be made, or at least time-limit such applications.

5.181 The Institute of Medical Illustrators recognised the need for increased consistency, but cautioned that a "'one size fits all approach' cannot work here".

5.182 However, the Medical Defence Union argued that the regulators should be able to determine the time limit "as this will be dependent on the type of health care professional and the risk that he or she is considered to pose to the public". The British Medical Association also argued this "should be left to individual regulators to determine, who may in fact wish to vary this from case to case". The General Chiropractic Council warned that:

> There is a danger of setting time limits without providing for exceptional cases. There are some cases where applications for restoration could reasonably be made falling outside the time period.

5.183 The Royal Pharmaceutical Society of Great Britain argued that:

> When a regulator erases someone from a Register they are in possession of the facts as to why that erasure is a proper and just sanction. They should then decide the timeframe required to resolve the issue, or provide a timeframe that would impose a sufficient sanction on the individual. This cannot be determined by overarching legislation.

5.184 An individual consultee (Lucy Reid) went further and suggested that "the statute should actually include circumstances in which it is entirely inappropriate for applications for restoration". She queried whether regulators should have to "reconsider the case at great expense and time to all involved" where a registrant had been erased for a serious, dishonest act.

Provisional Proposal 5-24: The statute should require each regulator to establish in rules a process for considering applications for restoration in cases which are not related to fitness to practise proceedings. The regulators would be given broad discretion to determine the precise process it wishes to adopt.

5.185 All those who expressed a view on the issue agreed that for restoration cases not related to fitness to practise, regulators should be able to develop their own processes.[37] For example, the Association of Regulatory and Disciplinary Lawyers did not consider that the argument in favour of consistency "is of the same significance in relation to this type of restoration application" and accepted "that there may be different factors affecting the different professions".

5.186 The Royal College of Surgeons of Edinburgh and the General Optical Council supported the proposal on the basis that it allows the regulators flexibility when delivering their functions.

5.187 The Health and Care Professions Council pointed out that it uses the term "readmission" to differentiate registrants having previously lapsed or voluntarily removed themselves from the register, from those struck-off through fitness to practise proceedings. The Nursing and Midwifery Council suggested that the terminology regarding such cases should be standardised in the statute.

5.188 The Professional Standards Authority recommended that the regulators should have a means of identifying those restoration applicants who "came off the register because of a fitness to practise concern, or while concerns about their fitness to practise were being investigated but had not concluded".

5.189 However, as set out above, the Administrative Appeals Chamber of the Upper Tribunal suggested that all restoration applications should be treated procedurally in the same way as an initial registration application and there should be a right of appeal to the First-tier Tribunal.

Provisional Proposal 5-25: The regulators should have broad powers to make rules concerning the content of the registers. The only exception to this approach would be that set out in provisional proposal 5-27.

5.190 A significant majority agreed that the regulators should have broad powers to make rules concerning the content of the registers.[38] For example, the British Pharmaceutical Students' Association was in favour of the General Pharmaceutical Council retaining discretion over the content of its register.

[37] Of the 192 submissions which were received, 35 expressed a view on this proposal: all agreed.

[38] Of the 192 submissions which were received, 37 expressed a view on this proposal: 32 agreed, whilst 5 disagreed.

5.191 The Scottish Government supported giving the regulators broad powers regarding the content of the registers but suggested there is already a "significant degree of commonality" in the information that is recorded and differences normally arise in relation to post-registration qualifications.

5.192 Those who disagreed with the proposal argued in favour of greater consistency. For example, the Nursing and Midwifery Council stated that:

> We believe there is merit in "the register" having a common meaning across the health care regulators. A common approach to what is in the public domain would help to clarify and manage public expectations. Beyond this basic dataset, it should be possible to reach agreement about the underpinning data that supports regulatory activity.

5.193 This view was supported by the General Osteopathic Council and the Royal College of Midwives, although the latter cautioned against publication of registrants' home addresses. UNISON argued for consistency since the data collected by the regulators "can be invaluable to workforce planning, therefore its significance should be recognised and data published on a regular basis".

5.194 The Patients Association felt that the register should only include those details pertinent to the practice of the registrant, namely "qualifications, registration status, specialism, name, title, gender and sanctions (both fitness to practise and non fitness to practise)". The Nightingale Collaboration agreed that the content of the public register should be limited.

5.195 Pharmacy Voice argued that the register should include the name and contact details of a company's superintendent pharmacist, and argued that this information is not easily accessible on the General Pharmaceutical Council's register unless the superintendent's name is known.

Question 5-26: Should the regulators be given broad powers to annotate their registers to indicate additional qualifications or should this power be subject to certain restrictions?

5.196 A majority agreed that the regulators should be given broad powers to annotate their registers to indicate additional qualifications.[39] For example, the British Medical Association argued that:

> The changing healthcare environment in the NHS, together with the proliferation of new titles both medical and non-medical has, we believe, made it more difficult for patients to make an informed choice about their treatment and their treatment providers. To this end, we believe that the regulators should be given powers to annotate their registers more fully in order to ensure clarity for patients.

[39] Of the 192 submissions which were received, 45 expressed a view on this question: 28 said that the regulators should have broad powers to annotate, whilst 17 said that this power be subject to certain restrictions.

5.197 The Department of Health agreed with annotation provided it "is in keeping with the principle of patient safety and is therefore meaningful to the public and employers". Similarly, the Scottish Government argued that:

> Any annotation should be relevant to patient care, patient safety and risk management, indicate a level of practice substantially beyond the requirements for basic registration, and be meaningful to the public rather than merely a reflection of qualifications.

5.198 The College of Social Work said that annotation would "go some way to meeting one of the recommendations of the Social Work Task Force report".

5.199 A significant number argued that there should be some restrictions. The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that the regulators "should only annotate qualifications for which they have set standards". The General Dental Council noted that it only includes post-graduate qualifications which it has "directly quality assured" and preferred that "there are no powers to recognise additional qualifications beyond those inherent in the membership of specialist lists".

5.200 The Nursing and Midwifery Council suggested that "only those qualifications required for practice should form part of the register". It pointed out that the law may require the inclusion of additional qualifications. For example, it is required to record nurse prescribing qualifications as a result of the Medicines Act 1968.

5.201 Some consultees felt that the deciding factors should be the scope of professional practice and public protection. The Registration Council for Clinical Physiologists argued that annotations should be limited to qualifications and experience which could result "in the practitioner undertaking a different level of function that could impact upon a member of the public's wellbeing, for instance the prescribing of medication". The Society of Chiropodists and Podiatrists argued that registers should only be annotated in the public interest, and that:

> The public interest criterion would be met if, by virtue of an additional qualification, a registrant is carrying out procedures or therapies that are significantly different from the new graduate standards of proficiency, and not simply extended scope.

5.202 Similarly, the Association of Clinical Biochemistry suggested that registers should only be annotated where "additional qualifications materially affect the functions which a registrant can fulfil or the professional level at which a registrant can safely practise".

5.203 The Chartered Society of Physiotherapy argued that:

> The purpose of additional annotations on a register should only be used in exceptional circumstances. This should be to identify those areas of professional activity that require a specific type of competence, achieved through post-registration professional development (ie that are clearly outside the remit of pre-registration education), the application of which carries specific patient safety risks such that only registrants who can demonstrate their successful completion of a relevant programme of learning and development can

be enabled to practise it. This might apply to areas of practice in which there is a legislative need to identify certain practitioners who can safely engage in it (eg non-medical prescribing), and where there is a higher risk of patient harm even if performed correctly (eg surgical and/or other invasive techniques).

5.204 The Health and Care Professions Council felt that there needed to be clarity about the purpose and meaning of any annotation. It pointed to its own approach whereby it will only annotate in exceptional circumstances where:

(1) there is a clear risk to the public if the register is not annotated and the risk could not be mitigated through other systems;

(2) annotation is a proportionate and cost-effective response to the risks posed;

(3) the qualification annotated on the register is necessary in order to carry out a particular role or function safely and effectively; and

(4) where there is a link between the qualification and a particular title or function which is protected by law.

5.205 The Professional Standards Authority also supported a limited power:

> This is on condition that the power is used only in situations where a risk has been identified that is best addressed by the regulator, and there is a clear benefit in terms of public protection in publishing information about specialist practice. It must not be used simply as tool for career development or a means for the regulator to charge additional fees.

Provisional Proposal 5-27: The statute should require all current fitness to practise sanctions to appear in the public register.

5.206 A significant majority agreed that the statute should require all current sanctions, including interim orders, to appear on the public register.[40] For example, the Parliamentary and Health Service Ombudsman agreed that current sanctions should appear on the register "for the sake of clarity and consistency".

5.207 The Scottish Government agreed that all sanctions should appear in the public register but in health cases "a bracketed entry" should be made indicating "health reasons".

5.208 Charles Russell LLP agreed that there was a need for consistency in this area, but thought that further clarification was required as to the meaning of "current".

5.209 However, a small number disagreed. For example, the Registration Council for Clinical Physiologists argued that this information should not appear in the public register but "should be kept by the regulator to ensure that no patterns of behaviour persist". UNISON also felt that "in a minority of cases registrants' own

[40] Of the 192 submissions which were received, 46 expressed a view on this proposal: 40 agreed, 4 disagreed, whilst 2 held equivocal positions.

safety could be put at risk by the publication of such information" and suggested that the regulators should take this into consideration and "hear evidence from either the registrant or their representative if they believe this is a risk".

5.210 The Department of Health, Social Services and Public Safety for Northern Ireland stated that "regulators need to be careful in publishing information that they do not add further, through publication, to the impact of any sanction they have imposed".

Provisional Proposal 5-28: The regulators should have discretion to include details of undertakings, warnings and interim orders in the public register (subject to the main duty of the regulators to protect the public by ensuring proper standards).

5.211 A majority agreed that the regulators should have discretion to include details of current undertakings, warnings and interim orders in the public register.[41] For example, Optometry Scotland said the proposal "will provide the regulator with the ability to make whatever decision is most appropriate and in the public's best interest".

5.212 Many supported this proposal provided that there were clear procedures in place governing retention and removal of information that is no longer current. For example, the Medical Defence Union argued:

> The purpose of fitness to practise procedures is not to punish registrants and they must be able to make representations to the regulators about their publication procedures if they are perceived to have this effect, especially if the original "sanction" is no longer current.

5.213 However, many of the regulators – including the General Medical Council, Health and Care Professions Council and General Optical Council – opposed this proposal because they argued that the publication of these sanctions should be mandatory. The Professional Standards Authority argued that "any regulatory action taken in response to a finding *or admission* of impairment should be visible on the register while it is in force". It also felt that it should be mandatory to publish details of all current interim orders "because of the severity of the alleged risk and ensuing regulatory action".[42]

5.214 The Scottish Government also argued that all warnings, undertakings and interim orders should be included in the public register, and that "consistency is required in the public interest".

5.215 However, Charles Russell LLP expressed concerns that details of interim sanctions may be published when the evidence relied on in support of the allegation has not been tested by a Fitness to Practise Panel. It felt that:

> In these circumstances it is our view that it would be unfair for interim sanctions to be published as the publication could be very damaging

[41] Of the 192 submissions which were received, 36 expressed a view on this proposal: 24 agreed, 11 disagreed, whilst 1 held an equivocal position.

> to a registrant's reputation and the allegations could, ultimately, be proved to be unfounded at the subsequent fitness to practise hearing.

5.216 Several consultees pointed out that interim orders will be replaced by a substantive order which will appear on the register if there is a fitness to practise finding and therefore argued they do not need to be recorded.

Question 5-29: Should the regulators be required to publish information about professionals who have been struck off, for at least five years after they have been struck off?

5.217 A significant majority felt that the regulators should be required to publish information about professionals who have been struck off for at least five years after the decision.[43]

5.218 The General Dental Council argued that a requirement in the statute would ensure consistency between the regulators and help to avoid disputes in relation to the Data Protection Act 1998 and Freedom of Information Act 2000. The Scottish Social Services Council also felt that "express statutory authority would mean there is less likely to be a legal challenge".

5.219 The Department of Health stated:

> We would have concerns about information relating to struck off practitioners being removed from registers after a period of time. The health care workforce is a highly mobile workforce and there is the potential for many struck off workers to seek work abroad. For this reason, our view is that information about struck off practitioners needs to remain as long as there is a possibility that the individual could seek work in a professional capacity.

5.220 The British Dental Association argued that "simply removing the name might not give the clarity required for public protection". Bupa stated that publishing this information would be of "great value" to future employers and "a useful tool in tracking specific cases".

5.221 The Professional Standards Authority reported instances "where individuals who have been struck off continue to practise under a different but related job title, thereby posing a clear risk to the public". The General Osteopathic Council agreed that the proposal could provide "an important public safeguard" where a practitioner chooses to "undertake similar practice using a non-protected title".

5.222 The Scottish Government argued that the regulators should publish information about all professionals who have been struck off and that timescales should not be applied because they "would effectively enable practitioners to seek registration with alternative regulators or in alternative countries/jurisdictions". It

[42] Emphasis in the original.

[43] Of the 192 submissions which were received, 48 expressed a view on this question: 39 said that the regulators should be so required, 6 disagreed, whilst 3 held equivocal positions.

added that the regulators (and those who run voluntary registers accredited by the Professional Standards Authority) should be required to notify other relevant bodies in this regard.

5.223 The Pharmaceutical Society of Northern Ireland felt that further consideration should be given "around cases where health professionals have been restored to the register" and where a relative of a deceased registrant asks for their sanctions to be removed from the register. The Professional Forum of the Pharmaceutical Society of Northern Ireland argued that erasure in health cases should not be included in the register.

5.224 The General Optical Council agreed that this information should be public but argued that it should not be located in the register but "should be clearly separated from the list of currently registered professionals, to avoid confusion". Similarly, the Nursing and Midwifery Council argued that regulators "should be free to decide in what form this information is made public".

5.225 However, a small number of consultees disagreed that the registers should include such information. The Health and Care Professions Council argued that:

> Someone who is struck off is no longer registered and is therefore no longer entitled to practise using the relevant protected title. Including the names of such former registrants in the regulators' public facing registers would be contrary to the purpose of those registers and increase the likelihood of confusion for members of the public.

5.226 The Society and College of Radiographers also stated:

> We believe it is unhelpful to the public understanding of registration to have this view potentially clouded by details of past sanctions. It is also unnecessarily punitive to the registrant to retain details of sanctions that are "spent".

5.227 The Institute of Medical Illustrators thought that the fact that an individual was not on the register "should be sufficient".

5.228 Some consultees argued that the regulators should have discretion over the publication of such information. The General Social Care Council felt there should not be any time limit on the publication of information in relation to individuals who have been struck off where "there are good public protection reasons why information about an individual who has been removed from or struck off a register should be made public":

> This is particularly the case in social care where an individual who has been removed from working as a social worker may nonetheless seek employment elsewhere in the social care sector. It is important that if an employer or service user wishes to find out about any possible sanctions against that individual that they are able to check the relevant professional register.

5.229 The Chartered Society of Physiotherapy argued that regulators should have discretion to, for example, record more serious sanctions for a longer time, but

remove more minor sanctions – particularly if they do not relate directly to patient safety –after a set period of time.

Question 5-30: Should the regulators be required to include in their registers details of all previous sanctions?

5.230 A small majority disagreed that the regulators should be required to include details of all previous sanctions in their registers.[44]

5.231 The Health and Care Professions Council argued that publication would send "confusing messages about the fitness to practise of a registrant who is no longer subject to sanction" and "would be punitive and contrary to the public protection purpose of fitness to practise proceedings". The Society and College of Radiographers agreed that it would be "unnecessarily punitive to the registrant to retain details of sanctions that are 'spent'".

5.232 The General Osteopathic Council felt that where the registrant has been found to be fit to practise following a time limited sanction, "it would be inappropriate for a register to indicate in this way that perhaps some practitioners were more fit to practise than others".

5.233 The Department of Health felt that the register should only include sanctions which are still in force, although regulators "should retain details of previous sanctions and these should be made available to prospective employers on request".

5.234 The General Medical Council pointed out that in its register previous sanctions can be viewed by selecting "a fitness to practise history tab", but that this information is not published on the register itself. It argued that this system "provides transparency about a doctor's fitness to practise history while making the important distinction between current and historical sanctions". The Nursing and Midwifery Council considered that information about previous sanctions should be retained by the regulator but, in order to avoid confusion and prejudice, "only current sanctions should be visible on the public register". The Royal College of Midwives suggested there should be a symbol in the register against the entry signifying that the regulator should be contacted for more information. Similarly, the General Pharmaceutical Council felt that previous "sanctions should, as a minimum, remain a matter of public record and be available on request".

5.235 Several consultees favoured discretionary powers in this area. The Association of Regulatory and Disciplinary Lawyers suggested that "previous sanctions should be included for different periods according to the gravity of the sanction". Similarly, Optometry Scotland said that inclusion of previous sanctions "would be dependent on the severity of the misconduct, duration since last offence and the overall risk to the public".

[44] Of the 192 submissions which were received, 42 submissions expressed a view on this question: 11 said that the regulators should be so required, 25 disagreed, whilst 7 held equivocal positions.

5.236 The Professional Standards Authority stated that it may not be appropriate to introduce a blanket duty to publish this information, but that regulators should nevertheless ensure that "where it is clearly in the interests of public protection, fitness to practise histories are made accessible".

5.237 The General Social Care Council distinguished public facing registers (where regulators should have discretion over the inclusion of previous sanctions) and the data held in relation to each registrant on the register which may not be publicly available (which should include all previous sanctions). It argued that "any sanction which has restricted the practice of a registrant should be made publicly available without any time restriction". For other lower level misdemeanours, the rules should stipulate how long sanctions appear in the register.

5.238 The Scottish Government also argued that only current sanctions should be on the registers but there should be "an exception clause" relating to:

> those situations where older sanctions may potentially impact on the ability of individuals to perform their current job (but where their fitness to practise has not been found to be impaired). Details of such sanctions could remain on individuals' files but would only appear in the public register where they potentially impact on their ability and fitness to practices.

Other comments

5.239 Several consultees – including the Parliamentary and Health Services Ombudsman – felt that sanctions in cases which related solely to a professional's ill-health should not be included in the register. The Medical Protection Society also suggested that sanctions which related indirectly to health should not be made public (for example, reference to a requirement for medical supervision).

5.240 The Royal Pharmaceutical Society of Great Britain argued that "where a case is pending, this should not be in the public domain". The Optical Confederation argued that "any decision taken by case screeners/examiners/Investigation Committees" should be excluded from the register.

Provisional Proposal 5-31: All the existing protected titles and functions that are contained currently in the governing legislation should be specified in the new statute.

5.241 An overwhelming majority agreed that all existing protected titles and functions should be specified in the new statute.[45] For example, West Sussex County Council said it would "welcome the inclusion of all the current protected titles being specified in the proposed new governing legislation". Similarly, the McTimoney Chiropractic Association felt "strongly that all protected titles/functions should be included in the new statute".

5.242 The Professional Standards Authority stated that:

[45] Of the 192 submissions which were received, 49 expressed a view on this proposal: 47 agreed, 1 disagreed, whilst 1 held an equivocal position.

> protected titles are important because patients and the public recognise them as indicators of competence and fitness to practise. Protection of title legislation gives regulators the power to ensure that the titles are not abused and the public put at risk as a result.

5.243 The Scottish Government supported the proposal to include all the existing protected titles and functions in the new statute on the understanding that it will need to "reflect devolved competence".

5.244 Several consultees argued that the current levels of fines are out of date, insufficient and do not provide an effective deterrent.

5.245 The Optical Confederation also pointed to the need to include in the statute a catch all provision to create an offence where a title is used to falsely imply that someone is registered.[46]

Provisional Proposal 5-32: Government should be given a regulation-making power to add to or remove any of the protected titles and functions.

5.246 An overwhelming majority supported the proposal that the Government should be given a regulation-making power to add to or remove any of the protected titles and functions.[47] For example, the Association for Nutrition agreed that the "government should be given a regulation-making power to add to or remove any of the protected titles of functions".

5.247 The Optical Confederation agreed that the regulators should not have powers to add to or remove any protected titles as this requires "a political policy decision to be made" about public protection, the introduction of criminal offences and the allocation of public resources. The General Optical Council supported a role for the Government due to the "impact of changes to protected titles and functions".

5.248 The Department of Health argued the powers to alter the protected titles should remain with the Privy Council.

5.249 The Allied Health Professions Federation agreed with the proposal, but with the caveat that any changes by Government must always follow:

> a thorough evaluation of need and impact, including the implications of any specific change on public understanding and on professions that already hold protection of title.

5.250 The Scottish Government supported the proposal, subject to it properly reflecting devolved competence. It believed that the proposed approach to protected titles would clarify their legal status, and also that:

[46] See, section 28 (1) (d) of the Opticians Act 1989.

[47] Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: 36 agreed, 2 disagreed, whilst 2 held equivocal positions.

> This approach would provide structure and a sense of control over the plethora of titles that have emerged and been adopted by healthcare professionals, particularly in recent decades. Whilst many working in healthcare environments understand the roles and responsibilities associated with new titles, patients/service users are often left confused regarding their meaning and resulting in the potential for them to be misled, thereby undermining their faith, trust and confidence in the professions.

5.251 The Professional Standards Authority argued that:

> Any decisions taken in this area should also be in full cognisance of the restrictions that protection of title and function can introduce into workforce dynamics, and the impact this can have on the labour market.

5.252 The Association of Clinical Biochemistry felt that the Government should have powers to add to protected titles and functions but that "removal should require a more stringent level of scrutiny".

5.253 A small number disagreed with Government regulation-making powers in this area. The Royal Pharmaceutical Society of Great Britain argued that the decision to add or remove protected titles or functions should rest with the Professional Standards Authority and "should be subject to scrutiny through reports and hearings by the House of Commons Health Committee". UNISON argued that our proposal could be seen as "political interference with a regulatory matter and undermine the independence of the regulators".

Question 5-33: How appropriate are the existing protected titles and functions?

5.254 A majority felt that the existing titles and functions were appropriate.[48]

5.255 Several consultees argued that the use of the titles "doctor", "surgeon" and "consultant" in a health care setting other than by a medically qualified practitioner is confusing to the public and open to misuse. For example, the Patients Association argued that patients are often led to believe that "podiatric surgeons" are medically qualified. The British Medical Association argued that non-medically qualified individuals should not be permitted to extend their titles in this way "as there is a clear overlap between such terminology and that used by medically qualified practitioners".

5.256 The Department of Health was also concerned about the use of titles by non medical professionals which imply that they might be medically qualified. For example, "use of the term 'surgeon' in job titles" and people avoiding the protected title regime by using another title which is not protected "for example 'foot care specialist' instead of 'chiropodist'". It wished to explore further the

[48] Of the 192 submissions which were received, 50 expressed a view on this question: 30 said that the existing protected titles and functions were appropriate, 8 said that there were issues regarding the scope of different titles and functions, 6 noted the complexity in this area, 2 argued for a general overhaul, whilst 4 argued that new titles should be included.

possibility of a power to enable specific titles to be banned in a health care context, other than by certain regulated professionals.

5.257 The Scottish Government also expressed concern over the use of titles which convey the impression that the person is suitably qualified and registered (such as the "widespread use of the term 'nurse', and increasing use of the terms 'surgeon' and 'foot specialist'").

5.258 However, the General Medical Council cautioned against extending the range of protected titles to terms such as "consultant" and "doctor" because of the high risk of unintended consequences. It thought that:

> It is of little regulatory significance if a person simply claims the academic title of doctor. It is of considerable significance if a person claims falsely to be a registered and licensed doctor. The public protection lies in the fact of the regulation and the fact that posing as a registered medical practitioner is a criminal offence.

5.259 Unite expressed concern that the titles "nurse" and "health visitor" are not protected (although "registered nurse" is) and suggested that registered nurses are sometimes "passed off" as health visitors despite not holding the relevant qualification. The Institute of Health Visiting also argued that the title "health visitor" should also be "protected in law once more", on the basis that:

> The term "health visitor" has been in use for nearly 150 years and it is a known and trusted brand, so it is meaningful to the public. The absence of a formal, legal definition of the title "health visitor" has led to confusion for professionals, employers and public alike.[49]

5.260 Several consultees felt that the title "specialist community public health nurse" should not be protected since it is not in common usage, causes confusion amongst professionals and the public, and is unnecessary since all practitioners must be a registered nurse or midwife.

5.261 The Nursing and Midwifery Council noted there is potential for confusion among members of the public where "nurse" is used "in relation to other, unrelated roles, such as veterinary nurse and nursery nurse". The Council recognised the concerns relating to "specialist community public health nurse" and suggested there may already be developments in the Government to address these issues.

5.262 The Society of Chiropodists and Podiatrists expressed concern about the use of the title "foot health practitioners" by unregulated professionals. The Society said that there was a need for some "creative thinking", in order that there can be "reasonable protection of function, whilst not stifling clinical innovation and development".

5.263 The Nightingale Collaboration also pointed to titles used such as "osteomyologist", "neurosteomyologist", "spine/spinal specialist", "spinologist" and "bonesetter" in order to undertake tasks similar to chiropractic or osteopathy.

[49] Health Visitor was a protected title up until 2001.

5.264 Similarly, the Association of Regulatory and Disciplinary Lawyers felt that:

> The protection rendered to the public where there is purely protection of a title, for example in the cases of "chiropractor" and "osteopath", rather than of actual function, is weak, given that a practitioner who is erased following a finding of unacceptable professional conduct may continue exactly the same form of practice upon the same patients immediately afterwards, provided s/he does so under a different title, for example "spinal therapist" or "manipulative therapist".

5.265 The Optical Confederation and Optometry Scotland argued that existing protected titles should be extended to include “ophthalmic”, “optical”, “eye health” and “eye care”.

5.266 The College of Optometrists supported the existing legislative requirement that the optometrist or medical practitioner who carries out the eye test must also carry out the examination for the purpose of detecting injury, disease or abnormality. An individual consultee (Richard Calver) argued that “sight testing” by dispensing opticians is not and should not be permitted, and that refraction does not lie within a dispensing optician’s core competencies.

5.267 An individual consultee (Dr Susan Blakeney) argued that “because of the limited experience in ophthalmology and contact lens fitting that most doctors receive during their training”, “only medical practitioners who have appropriate expertise in the protected functions should be allowed to provide them”.

5.268 In relation to pharmacy, Charles Russell LLP argued:

> Currently, the Medicines Act 1968 gives greater protection to the outdated title “chemist” than to the modern title “pharmacist”. In addition, there is some overlap between the provisions of the Medicines Act 1968 and the Pharmacy Order 2010, in that both create an offence of using the title “pharmacist” without being registered.

5.269 The Society and College of Radiographers argued there is an “urgent need for protection of titles pertaining to the practice of diagnostic ultrasound, specifically ‘sonographer’ and ‘ultrasonographer’”. The McTimoney Chiropractic Association argued that the titles “animal chiropractor” and “veterinary chiropractor” should be protected. The British Pharmaceutical Students' Association suggested that “pre-registration pharmacist” should be a protected title. The Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, felt that the range of psychologist titles needed “clarification and harmonising”.

5.270 The British Association of Social Workers felt that qualified social workers, who are working in a role that has another title but where there is a significant social work element, should be required to be registered with the regulator. Skills for Care said that it is “essential that social work remains a protected title and that social work functions can only be undertaken lawfully by registrants or certain registrants”.

5.271 The Institute of Health Visiting argued that the term "protected title" is "widely misunderstood to refer to protecting the profession/professional, so perhaps reference to 'formal' or 'legally defined professional titles' might be clearer".

5.272 The General Osteopathic Council argued that the statute should ensure that the offence captures those who do not use a protected title but cause or permit another person to make any representation about him or her to the effect that they are registered.[50]

5.273 However, the General Optical Council felt that the "scope and criteria of these broad provisions are not certain, and are expensive to test". It did recognise that they do provide some ability for it to act "when the spirit of the law is being breached by a misuse of title".

5.274 The Department of Health was also concerned about the widespread use of protection of function:

> To define a profession by reference to its functions could limit the flexibility of that profession to adapt to change and also reduce workforce flexibility, as other professionals undertaking similar functions might be prohibited from doing so. It is also rarely the case that a particular function is the sole preserve of a single profession and therefore attempting to protect the functions of a particular profession as a general approach to professional regulation could be cumbersome and unworkable.

5.275 The Scottish Government did not consider that the protection of functions is an area that should be regulated "as this would serve to restrict rather than enable the development of practice and practitioners that has featured strongly in health care delivery in recent years".

5.276 It pointed to a number of new roles which have emerged as a result of "new ways of working initiatives" – for example "Surgical Care Practitioner", "Physician Assistant", "Anaesthetic Practitioner" and "Emergency Care Practitioner." It said that these roles, "although unprotected, are associated with a heightened skill set (eg in relation to prescribing) and…the potential for an increased risk to patients".

5.277 The Scottish Government also stated that:

> We consider that the existing protected titles and functions are limited in their impact and do not take account of the array of new titles that have emerged in recent years. We would like to further explore the possibility of Governments being given the power to prohibit the use of titles which are not protected where there is evidence that they are being misused and therefore causing confusion.

[50] This formulation is used in the Health Profession and Care Professions Order 2001.

Provisional Proposal 5-34: The regulators will have powers to bring prosecutions and will be required to set out in a publicly available document their policy on bringing prosecutions (except in Scotland).

5.278 The vast majority agreed that the regulators should have powers to bring prosecutions, and be required to set out in a publicly available document their policy on bringing prosecutions (except in Scotland).[51] For example, the Professional Standards Authority stated that:

> It is important that protected titles retain meaning and integrity in the eyes of the public. If the misuse of title persists unchecked, the public is at risk of harm and regulation is at risk of losing public confidence.

5.279 The Scottish Government supported giving the regulators powers to bring prosecutions but suggested a single mechanism could be created whereby:

> all such investigations (and, indeed, those relating to fitness to practise) are considered and undertaken by one central body with representation from individual regulators as required (ie a 'hub and spoke' type of model).

5.280 An individual consultee (Stephen King) supported the proposal on the basis that "titles can only be protected if offenders are prosecuted if they fail to desist from using a protected title".

5.281 The College of Chiropractors and the Royal Pharmaceutical Society of Great Britain argued that our proposal should go further and require the regulators to uphold the protected titles of its registrants. The General Osteopathic Council also pointed out that it brought a private case in Scotland in respect of the misuse of a protected title.[52]

5.282 However, the Medical Defence Union questioned more generally whether prosecution of illegal practitioners is an activity that should be undertaken at all by the regulators since they "have powers in respect of their registrants but those who are practising illegally are by definition not registrants". It suggested that prosecutions should be publically funded. It explained:

> We make this point because there is a substantial cost attached to prosecuting illegal practitioners, in terms of the regulator's time and staff and of course financially and this cost is borne by registrants through their annual retention fees. We expect that very many registrants are not even aware they are funding prosecutions of illegal practitioners and that, even if they agree wholeheartedly that illegal practitioners must be prosecuted, in the current economic climate they may be dismayed to find they are expected to meet a cost that should arguably be funded from the public purse.

[51] Of the 192 submissions which were received, 40 expressed a view on this proposal: 36 agreed proposal, whilst 4 disagreed.

[52] *General Osteopathic Council v Sobande* [2011] CSOH 39.

5.283 It pointed to precedents where the police have brought successful prosecutions against practitioners "notably most recently of a 'dentist' for fraud and in such instances this is funded by the public purse".

5.284 Similarly, the Nursing and Midwifery Council disagreed that "it is the place of the regulator to bring prosecutions" and suggested the statute should make clear that prosecutions should be brought "by other legal agencies such as the police and Crown Prosecution Service".