PART 8
FITNESS TO PRACTISE: INVESTIGATION

Question 8-1: Should the new legal framework remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (subject to a requirement that cases where there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings)?

8.1 A majority agreed that the legal concept of an allegation should be removed and the regulators should be given broad powers to deal with all information and complaints in such manner as they consider just.[1] For example, the General Optical Council supported the proposal on the basis that "the ability to take a proactive approach is key".

8.2 The Medical Defence Union argued that the concept of an allegation is "too constraining" and most regulators already "investigate information from a number of sources, including taking it upon themselves to investigate matters of which they become aware". The Medical and Dental Defence Union of Scotland could "see force in the fact that the straitjacket of one, simple allegation may not capture all matters of concern to the public" and agreed with broad powers to initiate an investigation but with "an important caveat in relation to anonymous complaints".

8.3 The British Association for Counselling and Psychotherapy felt that the proposal would "help to remove the adversarial landscape in some instances, thus enabling ... alternative dispute resolution processes". The General Dental Council argued that "a flaw in the current system is that the regulator has to identify individual heads of charge at too early a stage". Similarly, the National Clinical Assessment Service felt that the "legalistic concept of allegation" encourages "a litigious or vexatious approach" and its removal was consistent with the approach taken in Australia and New Zealand.

8.4 The Nursing and Midwifery Council agreed with the suggestion in the question "insofar as it relates to the 'form' of an allegation" but did not support:

> any wording which might suggest that the regulators should be dealing with any complaints that do not include an allegation of impaired fitness to practise in the broadest sense.

8.5 RadcliffesLeBrasseur agreed there is "no need to preserve the concept of an allegation which is artificial" but argued the power of the regulators to initiate an investigation should be "objectively justifiable" due to the "chilling effect" of the initiation of an investigation for registrants.

[1] Of the 192 submissions which were received, 55 expressed a view on this question: 36 said the concept should be removed, 10 said it should remain, whilst 9 held equivocal positions.

8.6 The Health and Care Professions Council noted that it is already implementing the proposed approach in certain aspects of its procedures. The Council considered that the proposal gives regulators "flexibility in dealing with matters that fall short of finding that a registrant's fitness to practise is impaired, but which nonetheless raise concerns". The British Society of Hearing Aid Audiologists also welcomed the flexibility offered by the proposal to manage "information proportionately to the risk to public safety".

8.7 However, several consultees did not support removing the concept of an allegation entirely. For example, the Association of Regulatory and Disciplinary Lawyers argued that "it is important to maintain a clearly identifiable gateway to the fitness to practise processes".

8.8 The Osteopathic Alliance argued that the removal of the concept of an allegation "is open to abuse" and could lead to "McCarthy style witch-hunts based on personal prejudices". The British Psychological Society felt that it might "make individuals more vulnerable to malicious or misguided complaints". This view was shared by several others, including an individual consultee (Robin McCaffery) and the Association of Clinical Biochemistry.

8.9 The Professional Standards Authority felt this "would result in greater inconsistency between the regulators and within the regulators" in relation to the handling of fitness to practise matters, "as well as resulting in increased uncertainty for both registrants and the public".

8.10 The General Pharmaceutical Council said that it did not feel able to comment on the proposal to remove the concept of an allegation, "without an understanding" of what would replace it.

Provisional Proposal 8-2: The statute should provide that all the regulators will be able to consider any information which comes to their attention as an allegation and not just formal complaints.

8.11 A large majority agreed that all the regulators should be able to consider any information which comes to their attention as an allegation, and not just formal complaints.[2] For example, the British Association of Counselling and Psychotherapy said that if regulators were not able to do so, it would "make a mockery of stated aims of public protection". The Professional Standards Authority agreed that the proposal was "clearly in the public interest".

8.12 The General Pharmaceutical Council argued the proposal was "consistent with the principles of openness [and] transparency, as well as supporting equality and diversity". Most of the regulators noted that this proposal was consistent with their existing powers. The General Osteopathic Council supported this approach since "it makes the status of a 'Registrar's complaint' much clearer where there is no complainant/patient involved".

[2] Of the 192 submissions which were received, 51 expressed a view on this proposal: 42 agreed, 7 disagreed, whilst 2 held equivocal positions.

8.13 An individual consultee (James Kellock) agreed that there needs to be "a shift from regulators being entirely reactive" and described the current system as "to some extent hit and miss" in the sense that "while one member of the public will complain about a particular aspect of a registrant's behaviour/performance another will choose not to". He also felt that the proposal was important given "how few complaints regulators appear to receive from members of the profession about their colleagues".

8.14 The Scottish Government supported the proposal and felt there may be merit in providing guidance to regulators "in relation to policies and procedures that may assist complainants following the submission of information and/or the making of an allegation". It also supported the proposal that there is no set format for allegations.

8.15 The Royal College of Nursing agreed with the proposal but raised concerns about "overzealous" and "disproportionate digging" by the regulators. It noted:

> For example, we are aware that senior nurses and other staff have been requested by the Nursing and Midwifery Council to examine at length past complaints and patients records in healthcare settings where there some issues have been identified. This fishing exercise can be an onerous and costly one for employers and can lead to unmeritorious complaints being advanced in the name of public protection. In further examples in South West and South Wales, police investigations involving the allegation of neglect in relation to a patient in a nursing home, the Nursing and Midwifery Council required the referral of all nurses who had been working on the day and night shifts either side of the incident to be referred to the fitness to practise process. Many of the nurses had no contact with the particular patient and their cases were later dropped, but only after considerable anguish and cost had been expended.

8.16 The Royal College of Midwives thought that the proposal should be subject to a requirement for "clear evidence before such a case could proceed".

8.17 However, some consultees opposed the proposal. The College of Chiropractors argued that "regulators should concern themselves with formal complaints only". Unite argued that the statute should define the difference between "allegation" and "formal complaint".

8.18 The United Chiropractic Association felt that "formal complaints should be the bedrock of any investigation". It continued:

> The process itself is still adversarial in nature and without a complainant there are issues and concerns as to whether a registrant can receive a fair trial. If a registrar is a complainant there is a real concern that a panel will have difficulty exercising sufficient independence to ensure that a registrant receives a fair hearing pursuant to Article 6 [of the ECHR].

8.19 The British Pharmaceutical Students' Association opposed the proposal, as it thought that "ad-hoc information may not be sufficiently robust to form a true allegation".

Provisional Proposal 8-3: The statute should contain a clear statement that there is no set format for allegations.

8.20 An overwhelming majority agreed that the statute should contain a clear statement that there is no set format for allegations.[3] For example, the General Medical Council pointed out that the proposal is consistent with the Council's existing legislation and stated:

> We would like to retain this flexibility in order to respond to changes in the context in which we work, such as the complexity of cases, technological developments and changes in public expectations.

8.21 The British Association for Counselling and Psychotherapy agreed with the proposal insofar as it was "in support of accessibility aims and to enable vulnerable groups to complain". Similarly, the General Pharmaceutical Council noted the potentially positive impact of the proposal on equality and diversity.

8.22 The Professional Standards Authority agreed generally with the proposal but recognised that in practice it will be "difficult (or in some cases impossible) for a regulator to progress an investigation without a certain minimum amount of information". The Authority suggested that "encouraging the use of a standard format for such notifications, where appropriate, may enable the regulators to make more efficient use of their resources".

8.23 The Association of Regulatory and Disciplinary Lawyers agreed with the proposal but also stated that there should be:

> a requirement that any complaint should be provided in written form in order to avoid subsequent dispute as to the precise content of the initial complaint and to provide an unambiguous factual basis for the initial screening process.

8.24 Similarly, the Medical Protection Society contended:

> While we accept that information/allegations need not be required in writing *initially*, we say there should be a requirement that the regulator *record* verbatim the content of all communications with a complainant until, if he so chooses, he commits the complaint to writing. This would mean transcribing all telephone conversations and meetings between the regulator and a complainant.[4]

8.25 The Association of Clinical Biochemistry agreed that allegations must be "attributable and written, not oral".

8.26 An individual at a consultation event supported the principle behind the proposal, but cautioned that "regulators should not become a hot-line for rants from those who are generally unhappy with everything".

[3] Of the 192 submissions which were received, 40 expressed a view on this proposal: 37 agreed, whilst 3 disagreed.

[4] Emphasis in the original.

8.27 Some made suggestions for the wording of the statement. The Medical Defence Union felt that "it may be clearer if the statute said allegations can be made in any format, as that seems less prescriptive than putting it in a negative". The Professional Standards Authority suggested that the wording should be that the "regulators are not entitled to reject an 'allegation' solely because it is not provided in the format the regulator specifies".

8.28 However, a small number of consultees disagreed with the proposal. The Health and Care Professions Council argued that the statute should require that "an allegation must be made in the form required by Council". The Council pointed out that it currently publishes "a standard of acceptance for allegations" which sets out "what the appropriate format is and allows allegations to be taken via other means – for instance through the taking of a statement of complaint".

8.29 The British Medical Association disagreed with the proposal and argued that "there must be an element of responsibility taken by the complainant through registering their concerns formally". Furthermore, it felt that the proposal would have significant resource implications since the regulators would have to "go out actively seeking information that might suggest misconduct from all the sources of information that are freely available, for example online social media".

Question 8-4: Should the statute prohibit the regulators from setting a time limit for bringing an allegation against a registrant or should there be a consistent time limit for allegations across the regulators (and if so, what should it be)?

8.30 A significant majority argued that the statute should set a consistent time limit across the regulators (and of those, a majority said it should be five years).[5]

8.31 The General Medical Council supported a time limit because "it is difficult to conduct an effective investigation many years after the events that gave rise to the concerns" and "there is no public interest in pursuing cases that involve a protracted investigation with a low success rate".

8.32 The Royal College of Nursing supported the General Medical Council's current approach. The College reported that it had had:

> little success in challenging, in the High Court as abuses of process, the very stale cases (which also involve long delays to advance them due to the availability of witnesses or poor recollection of events after such a time). Similarly, we acknowledge the difficulties placed on regulators in advancing stale cases as above. It is also anachronistic to run such stale cases when the adjudicating Panel is required to judge the registrant's current impairment and not focus on the level of that person's fitness to practise up to a decade ago.

[5] Of the 192 submissions which were received, 51 expressed a view on this question: 9 said there should be no time limit, 39 said there should be a consistent time limit, whilst 3 held equivocal positions. Of those who said there should be a consistent time limit, 1 said it should be two years, 24 said five years, 1 said six years, whilst 2 said the limit depended on the seriousness of the case.

8.33 The British Medical Association argued that:

> It is unfair – and may lead to flawed judgements - for regulators to be able to investigate a complaint so long after the event that the complained-against will have no recall of, or access to the records of, a particular case. Moreover, the accuracy of testimony of key witnesses, including the complainant, may lessen over a period of time. After several years, the case should be able to lapse or not proceed further.

8.34 Similarly, Rescare also noted that "relevant people can forget over a period of time and relevant evidence can disappear".

8.35 The Health and Care Professions Council stated that its legislation – which includes no such time limit ("even before the person was registered") – caused "significant practical difficulties" when allegations were not reported "in a timely manner" and it was therefore forced to set a five year rule in its standards.

8.36 The Association of Regulatory Disciplinary Lawyers also agreed that the possibility of imposing time limits should be retained, although it "acknowledged that any prescribed time limit is to an extent arbitrary". The Association considered that a five year limit that was subject to exceptions would strike the "balance between the protection of registrants from having to meet old allegations and public protection".

8.37 Several consultees emphasised the importance of exceptions to the time limit in certain cases. For example, the British Psychological Society stated this would be important:

> in cases of allegations of sexual abuse as a child where the victim only becomes fully aware in adulthood of having been the victim of abuse, or, for other reasons, had not felt able to proceed earlier.

8.38 The Health and Care Professions Council suggested that there should be an exception where the allegations relate to criminal convictions, cautions and regulatory determinations "as there is no need to 'go behind' the decision of the court or tribunal which imposed the conviction". Many consultees also argued that there should be a further exception where there is a significant public interest.

8.39 The General Dental Council suggested that the statute should specify the following exceptions to the five year time limit:

(1) where the patient has only recently found out about the poor treatment, or was a child at the time of the treatment;

(2) in cases of assault or impropriety where there was good reason for the complainant not to have come forward before;

(3) where dishonesty has just come to light; and

(4) where delays have been caused through action taken by another body or person (eg a lengthy criminal prosecution).

8.40 The Professional Standards Authority suggested that the statute should specify that the time limit shall not apply:

> to allegations which are so serious that there is a real prospect that, were they to be found proved, a sanction of suspension or erasure would result – until such time as it is established that there is no real prospect of those allegations being found proved. That would ensure that the most serious allegations are at least the subject of a preliminary investigation by the regulator – who might only then reject them on the basis of the time limit if there is insufficient evidence to prove them.

8.41 The Scottish Government felt that any time limit should be waived "in certain/exceptional circumstances". It was also suggested that "the ability of regulators to close vexatious complaints should be considered" and that "the need to deal with matters efficiently and consistently should be explicitly stated".

8.42 The Department of Health, Social Services and Public Safety for Northern Ireland generally supported the proposals and stated in relation to time limits that:

> Serious activity coming to light after years should not be set aside because it is out of time. Of course this needs to be considered in the context that serious cases may contribute to crucial activity.

8.43 However, the Nursing and Midwifery Council was not convinced that the introduction of a time limit would be beneficial. It said that:

> Any such time limit would always have to be subject to being waived in exceptional circumstances in the interests of public protection. We are aware that at the General Medical Council where a five year time limit is in place, it has resulted in challenges and litigation from both sides over its application.

8.44 Instead, it was argued that the statute should make clear that at the initial consideration stage, "regulators are entitled to take into account the age of the allegation". Similarly, the Royal College of Midwives argued that the regulators should have the option "to consider time elapsed since an incident or incidents when initially deciding whether to proceed with an investigation".

8.45 The General Social Care Council also argued against a time limit as:

> This would restrict the flexibility of the regulators and their ability to protect the public. Serious concerns about the behaviour of a registrant should be subject to investigation irrespective of when they were committed or brought to the attention of a regulator.

8.46 The General Chiropractic Council and the British Society of Hearing Aid Audiologists were also among those consultees who opposed the introduction of a time limit.

8.47 The Medical Defence Union argued that "the time limit itself may need to differ between the regulators, as it may depend on circumstances specific to that profession".

Provisional Proposal 8-5: All the regulators should have the power to establish a formal process for the initial consideration of allegations (such as screeners).

8.48 All consultees who expressed a view agreed that all the regulators should have the power to establish a formal process for the initial consideration of allegations.[6] For example, the General Chiropractic Council said that it was "particularly pleased" with the proposal.

8.49 The National Clinical Assessment Service supported this proposal and noted that it currently provides such a service under contract to the General Dental Council. It said:

> Together we believe that the provision of this expert independent advice adds robustness, timeliness and aids defensibility. There may also be an opportunity to provide early advice on practice which may be sufficient to allay concerns raised and is also proportionate and outside the formal process.

8.50 The General Optical Council noted that it is currently required by legislation "to open an investigation into every complaint made", even those cases which are "relatively minor". It further argued that:

> If this power is available to regulators, it would allow procedures to be adapted to deal effectively with any changes in the health sector or respond to issues raised by the media. For instance, if a media report has the effect of raising a large number of complaints about a particular issue, with a number of similarities, the regulator could adopt a process to deal with such complaints.

8.51 The General Medical Council welcomed the proposal for an "enabling power". The Council considered that such a power would allow the regulators to introduce systems that were appropriate to the number of complaints they received, which it noted "varies significantly".

8.52 The Nursing and Midwifery Council supported the proposal but stated:

> In our view, closure of cases at this initial stage is best carried out against clear agreed criteria, by properly trained staff whose decisions can be recorded, checked, audited and quality assured in order to ensure consistency. Appropriate clinical advice may also be needed in some cases. The test at that initial stage should be whether the nature of the allegation made is such that [the] regulator's investigation process needs to be engaged at all. Screeners, as provided for in our current legislation, and as used previously by the General Medical Council, did not fulfil this function or add any value to the process. We would not support their retention in the new statute.

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

8.53 The Scottish Government agreed with the proposal and also suggested:

> We would like to explore whether there is a place in the new statute for having a central cadre of screeners/case handlers who would deal with the initial consideration of all allegations.

8.54 The Professional Standards Authority argued that any powers to sift out cases should be restricted to cases where the allegation:

(1) does not relate to a registrant;

(2) is vexatious;

(3) is made anonymously and no evidence to support it can be obtained; or

(4) where it does not concern a matter that could impair the registrant's fitness to practise.

8.55 It was also argued that there should be a duty on the regulator to refer any matter to the relevant body (such as another professional regulator, a professional body, Care Quality Commission or Ombudsman).

8.56 An individual consultee (Lucy Reid) argued that the legal framework should include a "requirement for local investigation and resolution to be attempted before escalating to the regulator".

8.57 The Royal College of Nursing argued for greater consistency between the regulators. It stated:

> We have seen cases arising from the same incident in a workplace, where the General Medical Council has decided that no action is needed against a doctor at the screening stage where the doctor faces similar charges to a nurse, whose case is referred on to a Nursing and Midwifery Council Investigating Committee. The doctor is spared the anxiety and cost of defending himself at this early stage by a screening process which examines the early evidence. The nurse or her representatives are obliged to fully investigate and respond to the early allegation (which will inevitably include collecting statements and testimonials) and will have had to suffer the impact of reporting the referral to her employers (with the associated stigma). In the end, generally, no case will be found against the nurse and so both professionals arrive at the same outcome, but the differing screening process of their respective regulators will result in a far more detrimental experience for the nurse.

8.58 The Health and Care Professions Council noted that it does not currently use its power to refer cases to screeners since "such a process adds unnecessary delay to the fitness to practise process", but agreed that the power should exist.

8.59 A number of consultees raised concerns about the situation where regulators receive a complaint but decide not to pursue it. The registrant is not informed and the information is retained and may be used if further complaints are received. The Medical Defence Union argued this was "clearly unfair because the first the registrant knows about the initial complaint is when a further (and possibly entirely different) complaint is received". Similarly, the Royal Pharmaceutical Society of Great Britain stated that "it does not allow the registrant to build a defence against these complaints or to take remedial action to redress the issue".

8.60 Several consultees argued that complainants must be made aware that their name and address will be made available to the professional involved and any other health care body who may be approached for information relating to the case. For example, the Royal Pharmaceutical Society of Great Britain said that this approach "should minimise the risk of malicious allegations being made against any registrant".

8.61 The Professional Standards Authority felt that the statute should make clear that a regulator "may take forward an allegation even in circumstances where the complainant at a later date seeks to withdraw their allegation". It said:

> We are aware that some complainants regard the allegation as being "their" complaint, and may fail to understand that a regulator is acting in the general public interest in investigating it rather than acting in their individual interests.

Provisional Proposal 8-6: The regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.

8.62 All of the consultees who expressed a view on this proposal agreed that the regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.[7] For example, the Society and College of Radiographers supported the proposal, and said that it "was accustomed to working in this way under the Health and Care Professions Council arrangements and believed this works well".

8.63 The Professional Standards Authority supported the proposal, but questioned:

> the basis for the decision … not to codify the prohibition on certain individuals from the initial consideration of cases. Doing so would provide greater consistency and might improve public confidence in the regulatory system.

8.64 The General Medical Council argued that Council members should be prohibited from this role (as well as investigation and adjudication). Subject to this, it was argued that the regulators should have discretion about who should undertake this task. Similarly, the Medical Protection Society thought that the "statute should set out the power, though not specify who should and should not undertake the task".

[7] Of the 192 submissions which were received, 46 expressed a view on this proposal: all agreed with the proposal.

8.65 The Royal Pharmaceutical Society of Great Britain said that a "robust open/transparent system should be put in place to justify the selection".

8.66 However, the Medical Defence Union argued that:

> The legislation should make it clear that regulators have an obligation, and not just a power, to prohibit certain people from undertaking initial consideration of information and specify that only certain people can undertake this task.

Provisional Proposal 8-7: The regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.

8.67 The vast majority agreed that the regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.[8]

8.68 The General Dental Council argued this proposal "would avoid unnecessary time and expense in processing cases where referral to a practice committee is inevitable". The General Pharmaceutical Council – which currently has powers to set referral criteria – also agreed with the proposal.

8.69 The General Optical Council noted that it is seeking to amend its rules so that "serious criminal convictions will be referred directly to the Fitness to Practise Committee". The Council believed that "regulators should have the power to establish their own referral criteria based on a risk analysis of their complaints and field of regulation".

8.70 The Medical Defence Union supported the proposal, but suggested that "such criteria and specifications should only be agreed subject to consultation with stakeholders". The Pharmaceutical Society of Northern Ireland agreed that any exercise of the proposed power "should be validated through a public consultation process".

8.71 The Association of Regulatory and Disciplinary Lawyers argued that the statute should limit those complaints which are to be referred to the Fitness to Practice Panel without further investigation as being "those relating to (a) certain serious criminal offences or (b) sentence".

8.72 The Health and Care Professions Council agreed with a power to establish referral criteria but disagreed that cases should be referred directly to a Fitness to Practise Panel. It argued that an "important procedural safeguard" was provided by ensuring a two-stage process, whereby an Investigation Committee "reviews the investigative efforts and determines whether there is a 'case to answer'".

8.73 The Scottish Government and NHS Education for Scotland thought that this was an area that would benefit from a consistent approach across the regulators. NHS Greater Glasgow and Clyde agreed and suggested that the Professional Standards Authority may have a role to play in promoting such broad agreement.

[8] Of the 192 submissions which were received, 49 expressed a view on this proposal: 46 agreed, whilst 3 disagreed.

8.74 A small number of consultees disagreed with the proposal outright. For example, the Optical Confederation felt the proposal would be "too prescriptive and fetter the powers of the Investigation Committee to make their determination" based on the individual circumstances of the case.

8.75 The Nightingale Collaboration objected to the proposal. It stated:

> We believe that consistency across the regulators is essential and that if this consistency is not achieved, the public will see the resulting disparity as some professions being held to lower standards that others – we do not believe this can be good for public confidence in that regulation.

8.76 The General Medical Council stated that it is seeking powers to give the Registrar the authority to order the erasure of registrants convicted of certain serious offences without the need for a hearing (with a right of appeal to the High Court).

Question 8-8: Should the statute impose more consistency in relation to the criteria used by regulators to refer cases for an investigation or the cases that must be referred directly to a Fitness to Practise Panel?

8.77 A majority answered this question in the affirmative.[9] For example, Coventry and Warwickshire Partnership Trust argued that:

> The greater the consistency of process the better health professionals and Trusts will understand the process, the more divergent processes are the greater the possibility that allegations and cases will be overlooked or not acted on. This would also mean that people from separate disciplines, being investigated for the same incident could be treated differently, which could cause confusion in the eyes of the public.

8.78 An individual consultee (Lucy Reid) argued there is currently too much variance across the regulators in this respect. She noted that:

> The Nursing and Midwifery Council is very inconsistent in standards of investigation and referral to fitness to practise and interim orders. One example is a case where a nurse had been arrested and released on bail for criminal neglect where the Nursing and Midwifery Council only referred to an Interim Orders Panel following a complaint to the Chief Executive.

8.79 The Professional Standards Authority felt the statute should require the regulators to establish referral criteria "in order to make their decision-making more transparent" and provide that:

> All convictions resulting in a custodial sentence should automatically be referred directly to a Fitness to Practise Panel, rather than leaving

[9] Of the 192 submissions which were received, 48 submissions expressed a view on this question: 32 said that the statute should impose more consistency, 15 disagreed, whilst 1 held an equivocal position.

> this to the discretion of the individual regulators. A lack of consistency in this area will not improve public confidence either in the individual regulators or in the system as a whole.

8.80 An individual consultee (Jacqueline A Wier) also thought that consistency "ensures that each registrant is treated fairly and with equity", and so would increase public confidence in regulation.

8.81 An individual consultee (James Kellock), although cautious about the extent to which consistency could be imposed, argued that:

> It would look very odd if for example one regulator mandated that all allegations involving a conviction for rape should go straight to a Fitness to Practise Panel while another was content that they should not, and be the subject of investigation.

8.82 The General Optical Council supported consistency "in relation to the types of cases" which should be referred directly to a Fitness to Practise Panel.

8.83 The Department of Health answered the question in the affirmative. The Scottish Government also argued that there should be greater consistency. It felt that:

> This might counter the view that different professions are treated differently and would assure the public that their allegations were being considered and treated equally by all the regulators.

8.84 The Patients Association thought that there should be a "minimum ceiling before cases are referred on to investigation that is defined in statute". It said that the "definition did not need to be especially prescriptive but a general definition of principle here would be useful".

8.85 However, some consultees disagreed outright with greater consistency. The General Dental Council argued "the professions are very different and disciplinary matters are context specific" and therefore:

> consistency could be imposed in only a very few types of case (for example murder) and these are so obvious there is no advantage in listing them in statute.

8.86 Bupa argued that a "general practitioner should be more accountable than a nurse" since it is generally the general practitioner that prescribes the treatment. The British Medical Association felt that "it should be for the regulator to ensure consistency" and did not think that "statutory imposition would help this process".

8.87 The Pharmaceutical Society of Northern Ireland argued that:

> Regulators should have the flexibility to decide how to manage allegations according to specific context and resources. The contextual patient safety risk remains different from regulatory body to regulatory body. What may be a proportionate fitness to practise process for one regulatory body may not be for another, on the basis of presented risk.

8.88 Similarly, the Optical Confederation cautioned against a "one size fits all" approach to regulation. It thought that:

> Account should continue to be taken by each regulator of the risk associated with each profession. In the case of optometry and dispensing optics, these are low risk professions and whilst there is scope for greater consistency in the rules of procedure across the regulators the issue of risk must not be disregarded.

8.89 The Confederation suggested that the "use of indicative guidance may assist".

8.90 The Scottish Social Services Council referred to its own procedures, and said that:

> We have found that the route set out in our Rules is an efficient way to proceed. We have been free to design this route because our legislative framework and Rules do not specify any particular structure for this work.

Provisional Proposal 8-9: The statute should enable but not require the regulators to establish an Investigation Committee.

8.91 A significant majority agreed that the statute should enable but not require the regulators to establish an Investigation Committee.[10] For example, the British Chiropractic Association supported the proposal, and said that, in respect of its members, it would favour the abolition of the Investigation Committee.

8.92 The General Medical Council stated that an Investigation Committee is "one model for making a decision about which cases to refer to a Fitness to Practise Panel but there are a variety of other models". The General Chiropractic Council stated that it "has no intention to establish an Investigation Committee under the new Act if it can possibly be avoided".

8.93 The Health and Care Professions Council also agreed with the proposal but wanted to retain an Investigating Committee in its structure. It said that:

> Due to the range of professions we regulate, and the small size of some of those professions, the use of Investigating Committee panels is an effective approach. It may prove difficult to obtain the profession specific input required, particularly for the smaller professions, using an alternative, such as case examiners …. The costs of operating Investigating Committee panels are relatively fixed (daily fee for panellists, plus expenses) and can be budgeted for with a high degree of accuracy.

8.94 The Association of Regulatory and Disciplinary Lawyers also supported the proposal, but on the basis that:

[10] Of the 192 submissions which were received, 45 expressed a view on this proposal: 39 agreed, 5 disagreed, whilst 1 held an equivocal position.

> Such committees may neither be the most efficient nor cost effective means of determining whether a complaint should be routed to a fitness to practise panel or some other disposal ordered.

8.95 The Royal college of Midwives agreed that "especially for those smaller regulators who receive few referrals, Investigation Committees may be an inefficient use of resources".

8.96 An individual consultee (James Kellock) supported the proposal but warned:

> First there is a danger that case examiners, if individually used too often, might become settled into a routine and not be sufficiently "fresh" or removed from the regulator. Second the structure of having as few as two case examiners obviously limits the amount of discussion and variety of views that are taken into account in reaching a decision, when compared with a committee of seven or eight people.

8.97 The Professional Standards Authority agreed with the proposal but argued that if the regulator imposes a warning at the investigation stage which will be published on the register, then it will be necessary to establish an Investigation Committee (or similar) in order to remain Article 6 compliant "ie to provide an opportunity for the registrant concerned to have a hearing before the warning is imposed".

8.98 Some suggested that the title "Investigation Committee" is misleading since the Committee does not usually question witnesses or obtain reports, but instead makes decisions on the papers presented by the regulator's staff.

8.99 The Medical Defence Union questioned "whether it is even necessary to specify an investigation committee in the statute". It suggested, in light of the broad powers proposed in the next proposal, that:

> It would be worth exploring whether there might be a more appropriate way to provide in the legislation for an investigation process that includes appropriate safeguards without mentioning investigation committees as that may prove too constraining.

8.100 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group supported the proposal, on the condition that whatever investigation process regulators implemented, "it must be clear and transparent and seen to be in the interest of the public and not the registrant".

8.101 The Royal College of Obstetricians and Gynaecologists thought that the establishment of an Investigation Committee should "depend on the case and not the profession".

8.102 However, a small number of consultees disagreed with the proposal. The Royal Pharmaceutical Society of Great Britain argued that investigating someone's fitness to practise is so important that statute should "dictate that the professional being investigated should be investigated by a committee that contains a member of his/her own profession".

8.103 The Medical Protection Society also disagreed and said that:

> While some smaller regulators may feel there is no benefit, an Investigation Committee does provide a necessary route to avoiding full fitness to practise hearings in specific circumstances … Having an Investigation Committee, which sits in public enables registrants and the public to understand the regulator's expectations, which screening decisions may not.

8.104 UNISON argued "there should be consistency across all regulators" on matters relating to investigation including "the requirement for thorough investigation and triaging of issues and the investigation committee model is a tried and trusted method of ensuring this".

8.105 The Royal College of Nursing stated:

> Our concern is that if there is no independent Investigating Committee intervening, a significant number of the cases which are considered and dismissed by the Committee currently will be escalated to a Panel and final hearing … we consider that the potential costs saving could be swamped by the additional costs of having to process and hear unmeritorious cases.

8.106 The Department of Health agreed that the regulators should be free to decide whether to have an Investigation Committee or not, although it noted that for some regulators this does allow for oral hearings to take place when issuing warnings (such as the General Medical Council).

Provisional Proposal 8-10: The regulators should be given broad rule and regulation-making powers concerning how and by whom an investigation is carried out.

8.107 All consultees who expressed a view agreed that the regulators should be given broad rule-making powers concerning how and by whom an investigation is carried out.[11] For example, the Society and College of Radiographers thought that "allowing regulators flexibility to determine the processes for investigation might mean less delay in hearing cases and less cost to registrants".

8.108 The National Clinical Assessment Service stated:

> Our experience of working with three regulators is that the investigation of a single incident does not give a view on safety across the full scope of clinical practice. However, a full assessment is not always indicated. [We have] therefore developed a process of local record review which could be used as a screening tool and which could potentially add swiftness and timeliness to investigations and subsequent resolution. An independent view is helpful in providing triangulation of evidence.

[11] Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: all agreed.

8.109 The General Optical Council agreed with the proposal but was concerned about "how this sits with the idea of harmonisation of process and public understanding". The Professional Standards Authority also supported the proposal but considered that there should be:

> consistency about the circumstances in which performance/health assessments may be requested and/or any measures the regulators should be able to take in relation to non-compliance by registrants. The current rules differ significantly across the regulators, for no good reason in our view.

8.110 The Royal College of Nursing agreed that the regulators should have broad rule-making powers "concerning how and by whom an investigation is carried out" provided the regulators are "required to establish a consistent system" including an investigating committee. It felt that:

> Consistency is key. We are aware from cases involving registered nurses and other clinicians, that the General Medical Council appears to adopt a far more thorough screening process leading to cases against doctors being closed at an early stage whereas the linked case against a nurse involved in the same set of facts will often proceed to a lengthy and costly investigation before being considered months later by the Investigating Committee.

8.111 Some consultees commented on the proposed powers for regulators to determine by whom an investigation is carried out. The British Pharmaceutical Students' Association said that "guidance or indication on who can carry out these investigations would be necessary to enjoy fairness". Similarly, the Royal Pharmaceutical Society of Great Britain thought that:

> Statute should dictate that the professional being investigated should be investigated by a committee that contains a member of his/her own professions, to provide context to the investigation.

8.112 The Department of Health, Social Services and Public Safety for Northern Ireland supported our proposals and stated that "legislation should simply accord [the regulators'] right/responsibility to carry out investigations".

Provisional Proposal 8-11: The statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.

8.113 The vast majority agreed that the statute should give the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.[12] For example, an individual consultee (James Kellock) thought that "one of the areas where the investigation of complaints could be improved is by giving regulators more powers to obtain relevant information". Bupa considered that the "current system is fundamentally deficient in respect of powers to require disclosure of information".

[12] Of the 192 submissions which were received, 49 submissions expressed a view on this proposal: 47 agreed, whilst 2 disagreed.

8.114 The General Medical Council stated that:

> This power is critical in enabling us to carry out our public protection role. In most cases, information is provided willingly and voluntarily but in a small number of cases we experience difficulties in obtaining information and, in these cases, it has been very important that we have the power to require disclosure. Recently, we have had to use this power to require the Independent Safeguarding Authority to disclose its reasons for placing a doctor on a barred list, where its own legislation does not provide powers to disclose such information to us.

8.115 The Nursing and Midwifery Council also agreed with the proposal on that basis that it "reflects our current powers and is essential for our public protection role". The Royal College of Nursing also supported the proposal "as this is the only way in which an expeditious and appropriate investigation can be conducted".

8.116 The Scottish Government agreed in principle with a power to require disclosure of information but felt that it was not always clear what information can be demanded and that guidance was needed on such matters.

8.117 Some consultees thought that there should be some restrictions on such a power. The Professional Forum of the Pharmaceutical Society of Northern Ireland reiterated that it did not support a "power enabling phishing exercises being carried out against registrants". UNISON noted that the powers must be "human rights and data protection compliant".

Question 8-12: Are the existing formulations of the power to require disclosure of information useful and clear in practice?

8.118 A majority of consultees thought that the existing formulations of the power to require disclosure of information were useful and clear in practice.[13] For example, Optometry Scotland was of the view that "the current powers are clear to all concerned".

8.119 The General Medical Council and the Nursing and Midwifery Council were both satisfied with their current powers to require disclosure, but noted that "robust enforcement" and "sanctions for non-compliance" would improve their effectiveness.

8.120 The Royal College of Nursing said that it "would welcome this as an opportunity to provide clarity for the regulators that the usual course for disclosure would be to seek to enforce any request in the civil courts".

8.121 However, some consultees thought that the existing formulations could be improved. For example, Coventry & Warwickshire Partnership Trust said that "further clarification and simplification of the powers would be beneficial".

8.122 An individual consultee (Lucy Reid) stated that:

[13] Of the 192 submissions which were received, 28 expressed a view on this proposal: 18 said that the formulations are clear, whilst 10 said that the formulations are not clear.

> The existing arrangements are not clear in practice neither are they useful, however this is largely due to a lack of clarity regarding the power to require disclosure versus the Data Protection Act and the understanding of such. The existing legislative framework is confusing and contradictory.

8.123 The General Optical Council believed that "some consideration needs to be given to … providing primacy to the view of the regulator that the information requested is relevant and ought to be disclosed".

8.124 The Scottish Government thought that "the existing formulations of the power could be clearer and as the powers vary between regulators; it is not straightforward what information can be demanded".

Provisional Proposal 8-13: The power to require information should be extended to include the registrant in question.

8.125 A large majority felt that the power to require information should be extended to include registrants themselves.[14] For example, the Patients Association believed that it is "important that specific provision is made in statute to ensure that the importance of disclosure is understood fully".

8.126 The Medical Defence Union agreed "because our experience is that the regulators already require information from the registrant" and "registrants are also under a duty of cooperation with inquiries". It also pointed out that this power would "of course be subject to the rights of any registrant and especially the rights in respect of self-incrimination". The General Dental Council agreed with the proposal and argued that "it is not self-incrimination to require the production of documents" and that "disclosure should be limited to matters which are relevant to the registrant's practice and not, for example, private emails and private financial records".

8.127 The General Medical Council also felt that the power should only be used to require registrants to disclose "key information that is critical to progression of a fitness to practise case such as the names and details of their employers". It continued:

> We are sensitive to the issues relating to self-incrimination in relation to the registrant's response to the allegations that have been made. We are also mindful of the needs of sick doctors in this context and would urge caution in requiring registrants to disclose their response to allegations. That said we believe that more can be done to establish a culture of openness between ourselves and doctors during an investigation and we are piloting meetings with doctors at the end of an investigation to support such openness.

8.128 The Nursing and Midwifery Council stated:

[14] Of the 192 submissions which were received, 37 submissions expressed a view on this question: 29 agreed, 5 disagreed, whilst 3 held equivocal positions.

> We think a permissive power to require some factual information to be provided by the registrant, such as their personal identification number, employer or agency details, current address and contact details, details of criminal proceedings or consent for us to obtain records relating to a conviction, would be very beneficial. We would also urge that this power to require disclosure be exercisable at all stages of the process. At present we can only require such information after an allegation has been referred to a practice committee.

8.129 The Health and Care Professions Council considered that the power to require information from the registrant "should extend only as far as requiring any patient and service user records held by the registrant concerned", because:

> Although such requests can be made by the data subject (complainant), in practical terms it would assist with case investigations and provide clarity if such records could simply be demanded directly from the registrant by the regulator.

8.130 However, the Council thought that the power should not extend to "any relevant material" and "requiring submissions from registrants". It felt that:

> Registrants should be able to maintain the right to remain silent or choose not to engage in the fitness to practise process. Evidence of genuine insight is especially important to panels that make fitness to practise decisions and any requirement for registrants to provide submissions or engage could potentially hamper a panel in forming a balanced view of the case and of assessing any likely risk of repetition.

8.131 The General Social Care Council agreed that the proposed power would need to be limited to the registrant's practice, but also acknowledged that "in social work, this can also involve matters outside of a work setting".

8.132 The Association of Regulatory and Disciplinary Lawyers agreed with the proposal provided:

> (a) that the registrant is entitled to rely upon his privilege against self-incrimination as a shield to such disclosure and (b) the power is restricted to the disclosure of information and not his case.

8.133 A small number of consultees disagreed outright with this proposal. The Medical and Dental Defence Union of Scotland argued that:

> In matters of professional regulation it is for the registrant to decide the extent to which he wishes to put forward his own defence and not to be required to disclose material which would otherwise not be compellable or which might tend to self-incriminate. If those charged with pursuing the allegation, are not in a position to prove their complaint then that should allow the complaint to fail.

8.134 The Medical Protection Society disagreed for the following reasons:

(1) the power could effectively shift the burden of proof from the regulator;

(2) the registrant's right to respect for his private and family life may be breached;

(3) legal arguments about the justification for requiring the disclosure sought will cause delay; and

(4) the power would be susceptible to abuse (for example, a vindictive or vexatious complainant or informant could gain access to information that they otherwise would not be able to see).

8.135 The Association of Clinical Biochemistry queried why the absolute right to remain silent under caution in criminal cases should be any less rigorous in fitness to practise investigations. The Royal Pharmaceutical Society of Great Britain also asked "where the balance between self incrimination under criminal law would be".

8.136 RadcliffesLeBrasseur argued that:

> There should be no obligation on the registrant being investigated to provide information. Such a power would make a hearing otiose and would be likely to work unfairly. The request for information could be a request that he admit the allegations, with a sanction if he failed to answer … Many registrants engaged in fitness to practise proceedings face significant difficulties as they no longer work in the environment in respect of which the complaint was made. Indeed in many instances the complainant is their former employer. Consequently the registrant has no or limited access to information or evidence and a limited capacity to carry out any investigations.

Question 8-14: Should any enforcement powers be attached to the power to require information?

8.137 A majority felt that enforcement powers should be attached to the power to require information.[15] For example, the General Chiropractic Council considered that there would be "little point in having the power [to require information] unless the power has some teeth". The Professional Standards Authority agreed that enforcement provisions would be required to make the power effective, but said that "it would be helpful to understand what these enforcement powers might be".

8.138 The General Medical Council argued that:

> Enforcement powers are critical to the effectiveness of disclosure provisions. We have experienced difficulties enforcing our powers in some cases and we are currently progressing legislative change to make that enforcement effective by introducing a power for an Interim Orders Panel to make an interim suspension order where a doctor has refused to comply with a requirement to disclose his employer/contractor for services.

[15] Of the 192 submissions which were received, 43 expressed a view on this question: 32 said there should enforcement powers, 4 disagreed, whilst 7 held equivocal positions.

8.139 The General Dental Council felt that where a registrant fails to comply with a disclosure request there should be an automatic referral to a Fitness to Practise Panel and "a scheme of fines should be an option but not mandatory".

8.140 The Nursing and Midwifery Council felt that non compliance should be a separate ground of impairment and the regulators should also have powers to impose an interim suspension order pending compliance. Coventry and Warwickshire Partnership Trust agreed that a model whereby a "failure to respond by the registrant would in itself be misconduct could be applied here".

8.141 The Health and Care Professions Council pointed out that its legislation makes it a criminal offence to fail to comply with a request without reasonable excuse.[16] Between April and December 2011 the power to request was used 16 times (out of 376 cases) and to date it has not been necessary to prosecute.

8.142 The Professional Forum of the Pharmaceutical Society of Northern Ireland said that it would "only support the use of enforcement powers which have been granted for a specific purpose by a Court of Law".

8.143 However, some consultees disagreed with enforcement powers. The Medical Defence Union argued that "there is already the safeguard of recourse to the courts". Similarly, the Association of Clinical Biochemistry disagreed since "the facility exists to present evidence to a court and obtain a court order, then contempt of court rules apply".

8.144 The National Clinical Assessment Service felt "there should be a duty of co-operation to provide information as requested and non compliance should be taken into account by the regulator".

8.145 The Medical and Dental Defence Union of Scotland felt there was force in the argument that inferences may be drawn where a registrant:

> fails voluntarily to disclose material but we do not feel that a registrant should be compelled to do so. This is still an adversarial and not a consensual process and that is the essential difference between regulatory process and civil proceedings.

8.146 The Royal College of Nursing felt that the registrant should not be compelled to make a disclosure but that the regulator should be permitted to "ask a registrant for disclosure with the request expressly stating that the failure to assist may result in a number of outcomes", namely that the case "may take longer to be resolved" and failure to assist "may be brought to any panel's attention … and the registrant may face certain consequences from having refused a reasonable request to do so".

8.147 The Royal College of Midwives thought that the issue of enforcement powers was a "difficult concept", and considered failures by a range of information holders, rather than just registrants. The College stated that:

[16] Health and Care Professions Order 2001, SI 2002 No 254, art 39(5).

> Healthcare providers have a duty to provide such information and there could be sanctions where they refuse, as to the registrant themselves and other professionals it is less clear.

8.148 The Department of Health wanted to explore further whether additional enforcement powers are necessary.

8.149 The Scottish Government was equivocal on enforcement powers and wanted to explore the option of "making non-responsiveness or non-disclosure ... grounds for professional misconduct".

Provisional Proposal 8-15: The statute should provide that the test for all referrals to a Fitness to Practise Panel across the regulators is the real prospect test.

8.150 The vast majority agreed that the test for referrals to a Fitness to Practise Panel across the regulators should be the real prospect of establishing impairment.[17] For example, the General Optical Council thought that "applying a consistent test across all regulators would support harmonisation and provide clarity for the public that there is parity in the way that all complaints against any health care professional are treated".

8.151 The General Dental Council agreed on the basis that "this test is the one used by courts now", there is "a body of case law as to its meaning" and "it is understood and workable". The General Medical Council argued:

> In our experience the test is effective in ensuring that cases are only referred to a hearing if a finding of impairment is a real possibility. It is in no-one's interests for cases to be referred to a hearing where there is no real prospect of a finding of impairment.

8.152 The Health and Care Professions Council pointed out that although its legislation does not contain the real prospect test, this test has been adopted by its Investigation Committee.

8.153 The McTimoney Chiropractic Association also supported the proposal, which it considered could "significantly reduce costs without impacting on public protection" by providing an alternative to the:

> current system where, should a conflict in evidence exist, (virtually all complaints), this must be referred to the Professional Conduct Committee, often resulting in a "no case to answer" finding.

8.154 However, some consultees disagreed with the proposal. The Nightingale Collaboration feared that "allegations could be dismissed before sufficient investigation has been carried out". It continued:

[17] Of the 192 submissions which were received, 44 expressed a view on this proposal: 43 agreed with the proposal, whilst 1 held an equivocal position.

> We believe this could also be seen as a lack of transparency and accountability because of possible bias and conflicts of interest. We recommend that any allegation that falls within the remit of the regulator should fully investigated and put before a Fitness to Practise Panel.

Provisional Proposal 8-16: The regulators should have powers to issue or agree the following at the investigation stage: (1) warnings; (2) undertakings; (3) voluntary erasure; and (4) advice to any person with an interest in the case. The regulators would be given broad powers to make rules governing the use of such powers. This would include rules governing who or which body can issue them and the circumstances in which the powers can be agreed or imposed.

8.155 A significant majority agreed that all the regulators should have powers to issue or agree warnings, undertakings, voluntary erasure and advice at the investigation stage, and broad powers to make rules governing the use of such powers.[18]

8.156 The Royal College of Nursing argued:

> The availability of these new sanctions at an early stage would encourage registrants and their representatives to engage in the fitness to practise process earlier. There are cases that we see at the current time, where the lack of lesser sanctions available to the Nursing and Midwifery Council at this stage, mean that it would not be in the registrant's best interests to make admissions and share information. This means that these less serious cases therefore proceed on into the fitness to practise process incurring time and costs of investigation. All parties would therefore be encouraged to explore a more practical outcome in these less serious cases.

8.157 The Medical Defence Union argued that "it must be left to the individual regulators to propose which of these powers it chooses" and "to change their rules in respect of these 'sanctions' including withdrawing the use of any of them at any time, again subject to consultation".

8.158 A consultee at a consultation event was concerned that allowing the regulators "to pick and choose exactly which disposals they adopt" is unhelpful and the approach to these types of disposals already varies between the regulators who impose different criteria for warnings.

8.159 Several consultees noted the potential advantages of being able to resolve cases at an early stage. Bupa considered that the proposal would "save time and costs". Similarly, the Medical and Dental Defence Union of Scotland supported the proposal "because of the cost, distress, and delay of requiring fitness to practise hearings to be held in cases which can be otherwise resolved by consensual means". The College of Social Work felt that the proposed powers would offer a "more flexible and proportionate response to less serious lapses".

[18] Of the 192 submissions which were received, 47 expressed a view on this proposal: 42 agreed, 1 disagreed, whilst 4 held equivocal positions.

Advice

8.160 Several consultees commented specifically on the power to give advice. For example, the General Medical Council argued that advice should be issued under a general rather than specific power, to ensure that it remains an "informal mechanism" and therefore "would not engage publication and disclosure requirements". It said that:

> Under a general power a letter of advice can still be referred to at the impairment and sanction stage of a fitness to practise hearing as a matter of fact. This reflects our current practice.

8.161 The Medical Protection Society was concerned that in relation to advice "any person with an interest" would be too wide "in that any person could claim to have an interest simply by virtue of being a member of the public". Similarly, the Association for Regulatory and Disciplinary Lawyers argued that this provision:

> raises what may be a contentious issue as to who may have an interest in the case. Further that interested party may not have been engaged or engaged fully in the investigative process and thus any advice issued may be founded on incomplete information.

Consensual disposals

8.162 A number of specific comments were made in relation to the use of consensual disposals. On the one hand, the Patients Association described consensual disposals as "inappropriate, unfair and obscure". It said that:

> A closed room with just representatives of the regulator and the registrant making a plea bargain feels deeply unjust … We fear that this public perception will ultimately damage the reputation of the professions and confidence in professionals, contrary to the proposed paramount duty.

8.163 On the other hand, the General Medical Council pointed out that its role is public protection rather than punishment, and said that:

> Where a doctor is willing to accept the sanction we believe necessary to protect the public, we cannot see the purpose of holding a hearing. Giving evidence at hearings is very stressful for witnesses and sometimes witnesses choose to withdraw from our procedures rather than give evidence at a hearing.

8.164 In cases of consensual disposal, it argued that the requirements of transparency and accountability do not require a public hearing. It thought that:

> Transparency and accountability could, for example, be assured by publishing details of the concerns and full details of the decision on the doctor's online record and by independent auditing of the decisions to ensure they reflect published criteria. The Professional Standards Authority could also be empowered to oversee such outcomes and challenge them if appropriate. We have invited the Professional Standards Authority to review the outcomes of the cases in our pilots later this year.

8.165 The General Optical Council argued that in relation to consensual disposal, the preferred concept is that the regulator issues these outcomes, rather than their being "agreed" with the registrant. It stated that:

> It is important that disposal of complaints prior to a formal hearing should not be seen as the registrant benefiting from a lesser outcome or collaborating with the regulator to avoid a public hearing. We would suggest that where a registrant has been issued with any of these outcomes, it may be appropriate for these to be a matter of public record. In any event, the meaning and purpose of any outcomes issued at this stage should be clear, relative to warnings and sanctions applied following a hearing.

8.166 The Royal College of Nursing argued that in order to provide an incentive to registrants, an assurance should be given that "admissions made in the consideration of an early consensual disposal of a case, could not be revealed at the final fitness to practise hearing". It was argued this would also help the regulator in that the registrant would not be able to bring to a panel's attention the fact that the regulator had considered consensual disposal but decided against it.

8.167 Several consultees argued that the granting of voluntary erasure in fitness to practise cases "should always be based on the presumption that the doctor will not seek to be restored to the register at a future date".

Warnings

8.168 Some consultees commented on the use of warnings. The Nursing and Midwifery Council felt it was "unhelpful" to allow warnings to be issued at two different stages in the process. Its system of "cautions" can be imposed only following a finding of impairment, whereas at other regulators they can be issued by investigators where there is no realistic prospect of proving impairment. The Council said that:

> If [warnings] are most effective when used as a sanction in cases falling short of impairment, then they should be imposed at this stage, but if they are properly regarded as a less serious sanction than suspension or conditions following a finding of impairment, then they should not be available at the investigation stage. In our view they cannot be used at both stages.

8.169 Similarly, the Royal College of Midwives argued it was:

> unclear what the purpose of a warning at investigations stage could be. Perhaps where a registrant admits the charges but it is clear that they do no amount to impairment of practice they could be used but perhaps a condition of practice order might be more appropriate. Warnings should perhaps be reserved for the hearing stage.

Other comments

8.170 The General Medical Council argued that "suspension and erasure should also be available" at the investigation stage.

8.171 An individual consultee (James Kellock) felt that there should also be a "power to agree financial reimbursement to the patient". He asked:

> Why should a patient who has undergone inappropriate or incompetent treatment and paid for it have to initiate a separate process to recover the sum he should not have paid?

8.172 Some consultees argued that there should be a power for the regulators to require an apology from the registrant.

8.173 The Professional Standards Authority argued that:

> There would be significant value in terms of improving public understanding of and confidence in the regulatory framework if the regulator's rules about the issuing/agreement of these outcomes were consistent. We also consider it important for the regulators to establish clear criteria and processes for decision-making in relation to these outcomes, as well as to demonstrate rigorous quality assurance of the decisions actually made …. Our preference would be to ensure that such decisions are only taken after sufficient investigation of the underlying concerns, and that there is provision for robust oversight of such decisions.

Question 8-17: Should the statute require that any decision to use any power listed in provisional proposal 8-16 at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel? Alternatively, should the powers of the Professional Standards Authority to refer decisions of Fitness to Practise Panels to the High Court be extended to cover consensual disposals?

8.174 A majority felt that any decision to issue warnings, undertakings, voluntary erasure and advice at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel.[19] For example, the British Dental Association was concerned "that a *published* warning could be given by a small group of case examiners" and therefore "another tier is needed when measures are taken that could adversely affect the practitioner's livelihood".[20]

8.175 The Health and Care Professions Council considered that "it is appropriate for cases to be considered for consensual disposal only once a case to answer decision has been made" – this "prevents regulators from diverting cases which would not otherwise have been referred to final hearing through this process". Under its rules the decision to dispose of a case via consent is considered by a Fitness to Practise Panel and therefore the Professional Standards Authority has the jurisdiction to review cases.

8.176 The Professional Standards Authority argued that "public confidence would be compromised" if there was no independent oversight of these decisions and that:

[19] Of the 192 submissions which were received, 46 expressed a view on this question: 29 said that the statute should so require, 16 disagreed, whilst 1 held an equivocal position.

[20] Emphasis in the original.

> If such decisions were approved by fitness to practise panels, they might automatically fall within [our] jurisdiction if they amounted to "final" decisions. If they did not amount to "final" decisions they might nevertheless fall within our initial stages audits. However, the audits only look at a sample of each regulator's caseload, so provide less assurance in relation to individual outcomes than the scrutiny of "final" fitness to practise decisions.

8.177 The General Chiropractic Council stated that it would "ensure there was proper oversight, particularly of any consensual disposal" but the particular form of oversight should be left to the regulators.

8.178 The Patients Association argued, in relation to consensual disposals, that:

> If they must be done, these hearings must be done in the open or at the absolute very least the patient/complainant must have a role in the consensual disposal process.

8.179 However, the General Medical Council opposed any requirement that a formal panel should approve or make any such decisions. It said that:

> This suggests that the Registrar is incapable of entering consensual arrangements that are appropriate and in the public interest. We have been using consensual disposal with great success for many years and all use of discretion is subject to review by the courts and can be challenged. Introducing such internal formal constraints will introduce substantial delays and bureaucracy when there is no evidence that such restraints are necessary.

8.180 The Medical Defence Union argued that it would be "counter productive to require a regulator to seek approval from a formal committee" for decisions made through consensual disposal. It continued:

> This would have to result in a mini-hearing and engender much of the delay and additional cost that currently exist and that are part of the main rationale for the introduction of consensual disposal. It is unlikely that consensual disposal would work in terms of making the efficiencies and savings that are envisaged if there was a requirement for decisions to be approved by a committee or Fitness to Practise Panel. The procedure is not meant to be punitive and there will be lay and legal involvement in decisions that are made and we can see no good reason, therefore, to prolong the decision-making process by building in a further approval stage.

8.181 Several other consultees thought that a requirement of approval by a formal committee or panel would undermine the benefits of concluding matters at the investigation stage. For example, the British Chiropractic Association said that "such a requirement will negate the swifter nature of screening and consensual disposal". The Association of Regulatory and Disciplinary Lawyers agreed that approval would "defeat the objective of dealing with such cases efficiently and expeditiously".

8.182 The Society and College of Radiographers did not believe that consensual disposals should have to be approved by a formal committee or panel but suggested "these agreements should be audited to ensure consistency across individual cases and between professions" and that such audits should be undertaken by the Professional Standards Authority.

8.183 As an alternative to a formal panel, the Medical Protection Society suggested that:

(1) the complainant and registrant should be allowed "a reasonable opportunity to make representations to the regulator where the use of a power is being contemplated";

(2) any decision to use a power "must be made unanimously by two case examiners comprising one lay member and one member from the registrant's profession";

(3) any decision to use or not use a power should be explained by the case examiners by providing their reasons in writing; and

(4) any person or body that the regulator considers to have a sufficient interest in the case or indeed the regulator itself, could seek a review of the decision.

8.184 The Department of Health agreed that the regulators should have broad powers to issue or agree warnings, undertakings, voluntary erasure and advice at the investigation stage. It also argued that where there is a disagreement about the use of these powers, cases should be referred to a panel.

8.185 An individual consultee (James Kellock) said that:

> if both the regulator, acting in the public interest, and the registrant, agree the facts, the basis for impairment and the sanction, it is difficult to see why the profession, and ultimately the public, should bear the cost of expensive proceedings (the need for public understanding can be met in ways other than a public hearing, for example by a reasoned decision being published).

8.186 Similarly, the General Optical Council said that:

> This is about public protection and doing so in a proportionate way. Only a small number of cases will fall into this category, and the guidance could provide that the most serious cases must be referred. We would refer back to the point that fitness to practise is not about punishment. By restricting or removing a registrant's right to practice, the public is protected. We understand that there may be a desire to see a public hearing in all cases, but we believe that a balanced approach could accommodate disposal of cases without a hearing.

8.187 A large majority felt that the Professional Standards Authority's powers to refer decisions of fitness to practise panels to the High Court should be extended to cover consensual disposals.[21]

8.188 However, a small number disagreed. UNISON argued that this would inhibit the use of consensual disposals. The General Osteopathic Council felt that it would be more appropriate "to include any 'undue lenience' concerns around consensual disposals within the rights to initiate a review". An individual consultee (Jacqueline A Wier) considered that "the ability of the fitness to practise panel to approve a decision at the investigation stage should be sufficient without recourse to the Professional Standards Authority".

8.189 The General Dental Council thought that the Professional Standards Authority's powers to refer decisions to the High Court should only be extended in respect of voluntary erasure. The Council said that:

> Voluntary erasure is an exception as the circumstances leading to it are so diverse. Some of these are appropriate for the Professional Standards Authority's powers of referral and some are not. The General Dental Council would suggest that there need to be rules setting out which are the appropriate circumstances.

8.190 The Department of Health felt that an impact assessment should be completed before any decision is made about extending the powers of the Professional Standards Authority to refer cases to the High Court.

Provisional Proposal 8-18: The Government should be given a regulation-making power to add new powers to those listed in provisional proposal 8-16, and to remove any powers.

8.191 A large majority agreed that the Government should be given a regulation-making power to add or remove disposal powers.[22] The General Medical Council argued that a Government power would "future proof the process should a different approach be considered necessary at a later date". The Royal College of Nursing agreed that the inclusion of a Government regulation-making power in the statute would future proof the legislation.

8.192 The General Dental Council agreed with the proposal but felt there would not be any circumstances where any of those powers would be removed.

8.193 However, some disagreed outright with the proposal. UNISON argued that this proposal "gives Government too much power and could undermine the independence and confidence of regulators". The Society and College of Radiographers felt that Governments "may be swayed by political considerations which may occur due to a particular case" and wished to "avoid the perception that professional regulation is subject to political 'knee jerk reactions' to specific cases". The Royal College of Midwives shared these anxieties and thought that the purpose of the proposal was "unclear and brings in political interference".

[21] Of the 192 submissions which were received, 35 expressed a view on this question: 27 said that the power should be extended, 6 disagreed, whilst 2 held an equivocal position.

[22] Of the 192 submissions which were received, 38 expressed a view on this proposal: 33 agreed, 2 disagreed, whilst 3 held equivocal positions.

8.194 The Professional Forum of the Pharmaceutical Society of Northern Ireland proposed that such powers should be "subject to the agreement of the devolved administrations".

Question 8-19: Does the language used in the proposed list of powers contained in provisional proposal 8-16 convey accurately their purpose?

8.195 A majority felt that the language used to describe the proposed powers accurately conveys their purpose.[23] For example, the Medical Defence Union said that it was "not aware of any difficulties with the language and believe it is easily understood". The General Osteopathic Council was also "content with the categories as described".

8.196 However, some consultees thought that the language required further consideration. For example, the Royal College of Radiologists said that "if the test of the language used is public confidence, then the terms should be clarified to enable this".

8.197 Of those who disagreed, most argued that the term "voluntary erasure" was not clear.[24] The Nursing and Midwifery Council questioned the use of the term when many regulators do not use the phrase "erasure". The General Dental Council felt that "voluntary erasure" implies that "this is purely at the registrant's choice and that they may have evaded a just disposal of the matter" and therefore suggested "agreed erasure". Alternative suggestions included "erasure by mutual consent", "consensual erasure", "voluntary removal" or "removal by consent".

8.198 The General Medical Council suggested that the term for "voluntary erasure" must be distinct from the term used when a Fitness to Practise Panel erases a doctor from the register or "when, under the consensual disposal provisions, the regulator demands and the registrant agrees that their name be removed from the register".

8.199 Some consultees felt that the term "warnings" was not appropriate and preferred "caution". An individual consultee (Lucy Reid) felt that the term "warnings" can be misunderstood and can be seen by the public as "merely a slap on the wrist".

8.200 The General Dental Council felt that "undertakings" suggests that "a registrant has simply promised to behave properly; it does not in itself imply that there are conditions or monitoring in place" and suggested "conditions" or "agreed conditions". Similarly, NHS Greater Glasgow and Clyde suggested that it should be made clear that "undertakings" are mandatory, by using the term "conditions".

8.201 The General Social Care Council felt that "'undertaking' would be viewed as obscure by members of the public and does not fully capture the nature of the arrangement" whereby "the registrant has agreed to amend his or her practice or behaviour as a condition of being allowed to hold a licence to practice".

[23] Of the 192 submissions which were received, 39 submissions expressed a view on this question: 24 said that the language does convey the purpose, 15 disagreed.

[24] Three consultees said that the term "warnings" was not clear, 4 said that "undertakings" was not clear, 11 said that "voluntary erasure" was not clear, whilst 1 said that "advice to any person with an interest in the case" was not clear.

8.202 The Scottish Government supported the General Medical Council's proposal "to replace the term 'voluntary erasure' with 'erased by mutual consent'". It stated:

> However, we consider that this sanction needs to be supported by robust safeguards before this step is taken to assure patients that adequate steps have been taken to protect their interests and maintain their confidence in the professions (for example all outstanding concerns, allegations or potential fitness to practise issues would need to have been satisfactorily addressed and answered before such an application was finally processed).

Question 8-20: Is the use of mediation appropriate in the context of fitness to practise procedures?

8.203 A majority felt that mediation was appropriate in the context of fitness to practise procedures.[25] For example, an individual consultee (Robin McCaffery) described the proposal as "a good idea not based on confrontation".

8.204 The Scottish Mediation Network argued that:

> Mediation can be particularly useful where the registrant has made a mistake that has caused harm to a complainant, but is unlikely to repeat the mistake, and is assessed as being currently fit to practise. The regulator may choose not to impose any restrictions on the registrant and this may lead the complainant to feel that their complaint has not been taken seriously. Mediation can be used in such circumstances to facilitate a face to face discussion allowing complainants to receive an explanation and, where appropriate, an apology. It may also enable registrants to improve the quality of their future practice through hearing first hand about the impact of their actions on complainants.

8.205 The United Chiropractic Association also supported mediation and argued that:

> Many complainants would much prefer resolution of their complaints by way of an apology and assurances in relation to improvements in practice/communication in the future. Many are not aware of the severe implications on the professional of disciplinary hearings and if they were so aware would not wish to pursue the complaint.

8.206 An individual consultee (James Kellock) felt that mediation was appropriate where "the registrant appears not to understand the impact [their] behaviour has had on the patient" and "where the fundamental issue concerns communication":

> I am a mediator and know how beneficial mediation can be to both parties in a dispute in terms of moving on. I can quite see that some registrants against whom allegations have been made would be receptive to, and would benefit from, mediation in understanding how they can improve their professional practice to provide better service and to enhance patients' experiences.

[25] Of the 192 submissions which were received, 59 expressed a view on this question: 41 said mediation is appropriate, 12 disagreed, whilst 6 held equivocal positions.

8.207 Several consultees suggested that mediation should take place before an investigation has concluded. For example, the General Osteopathic Council argued this would ensure that mediation determined "the nature of the allegations rather than for there to be a mediated outcome to a panel decision on impairment". In contrast, the Medical Protection Society felt that mediation should be used after a finding of impairment by a Fitness to Practise Panel, "either in addition to or (in appropriate cases) in place of a sanction being imposed".

8.208 The Medical and Dental Defence Union of Scotland felt that mediation:

> could be used at an early stage to resolve complaints based on misunderstanding or to acknowledge mistakes but [we] do not believe it should be used in relation to determinations or negotiated outcomes. Equally, the involvement of the regulator itself in mediation is problematic and compromises the ability of both the regulator and registrant to take adversarial views where properly necessary.

8.209 Rescare commented that "mediation may be appropriate in a limited number of fitness to practise cases, where a mistake or omission is unlikely to be repeated". Thompsons Solicitors thought that "mediation could be useful and that it could avoid lengthy hearings if it is agreed to by both the registrant and the complainant".

8.210 The Professional Standards Authority said that it:

> did not see much scope for mediation for those complaints which are likely to pass the 'real prospect' test for the obvious reason that by definition there is a public interest in the matter being dealt with fully if there is a real prospect of a finding of current impairment being made. Similarly we see little scope for mediation where there is no complainant as such (eg in cases arising from notification of criminal convictions or in cases arising from ill-health).

8.211 The Department of Health was not convinced that mediation has a role in fitness to practise proceedings – given that the purpose is to determine impaired fitness to practise. But it also noted that litigation is expensive and time-consuming and wished to explore the issue of mediation further.

8.212 The Scottish Government, although generally not supportive of mediation, felt that it does give complainants and other injured parties "the opportunity to explain how they were affected by the events in question" and "provide registrants with the opportunity to apologise and/or explain what happened, depending on the individual circumstances of the case". Thus "appropriate sanctions could then be determined on this basis". It also argued that if a mediation scheme is adopted, this would benefit from "a central resource that all regulators could use rather than each regulator adopting individual systems and processes for medication".

8.213 However, a number of consultees remained opposed to mediation in a fitness to practise context. The General Medical Council argued that:

> Regulators must always seek the minimum outcome necessary to protect the public and retain confidence in the profession. If such an outcome was subject to negotiation with the registrant, by implication

> the final agreed outcome could be less than that necessary to protect the public.

8.214 Charles Russell LLP argued that:

> Unlike civil claims, the registrant does not have the ability to compromise the proceedings, so avoiding the costs of a final hearing. If mediation were to take place at an early stage, registrants will be hampered by the fact that they may not have received all the evidence which the regulator will be intending to rely on, any may not have had the opportunity to formulate their defence, including instructing any expert witnesses, or obtaining witness statements.

8.215 The General Social Care Council did not consider that "mediation in relation to fitness to practise issues in the context of social work would be appropriate".

8.216 UNISON referred to the Health and Care Professions Council's consultation on mediation, and said that "the fact remains that [mediation] is rarely used". It went on to say that whilst it:

> is very keen to explore all possible alternatives to the costly, resource intensive and extremely stressful process of going to a hearing we urge caution in this area.

8.217 The Department of Health, Social Services and Public Safety for Northern Ireland questioned "the value of mediation and where it fits in".

Provisional Proposal 8-21: All regulators should be given rule and regulation-making powers to introduce a system of mediation if they wish to do so.

8.218 A large majority agreed that all regulators should be given rule-making powers to introduce a system of mediation if they wish to do so.[26] For example, the British Pharmaceutical Students' Association said that:

> It is difficult to predict the role of mediation within the General Pharmaceutical Council but giving regulators the power to introduce mediation would enable them to fully research its advantages and disadvantages whilst also consulting with the profession and public.

8.219 Several consultees argued that mediation should be enabled by the statute but subject to proper safeguards and limited circumstances. In addition, the Health and Care Professions Council pointed out it will begin a mediation pilot next year.

8.220 The Society of Chiropodists and Podiatrists agreed with the proposal to give regulators powers in this area, but noted that:

[26] Of the 192 submissions which were received, 50 expressed a view on this proposal: 39 agreed, 8 disagreed, whilst 3 held equivocal positions.

> there is no comment on how mediation would be paid for. We would expect regulators to weigh up whether mediation would save money in the long run by resolving disputes without recourse to fitness to practise processes, or simply create an extra burden of activity.

8.221 The Professional Standards Authority felt that the statute should impose:

> a degree of consistency across the regulators in terms of the types of cases that might be suitable for mediation as well as the overall framework of the mediation processes to be used. Otherwise they may develop inconsistent criteria, which will not improve public confidence in the regulatory system more generally.

8.222 The Welsh Government supported giving the regulators powers to mediate, but said that:

> it is important that all regulatory bodies apply a similar model to demonstrate equity of management of fitness to practice cases. Rule and regulation powers may not be appropriate but a sharing of good practice and applicability across all regulatory bodies would be supported.

8.223 The General Optical Council argued that the regulators should have the power to "finance services for mediating complaints about the quality of goods and services provided by registrants that do not relate to fitness to practise concerns", such as the Optical Consumer Complaints Service.

8.224 Several consultees agreed with the proposal but retained some reservations about the use of mediation. For example, the Patients Association stated that:

> There appears to be some cognitive dissonance amongst the regulators who claim that mediation is wrong and opaque yet are in favour of using consensual disposals which are certainly not transparent. We are not wholly in favour of using mediation as it may not be the most effective tool in protecting future patients. That being said, mediation allows patients and service users to be directly involved in the process.

Provisional Proposal 8-22: The statute should provide for a right to initiate a review of an investigation decision in relation to decisions: (1) not to refer a case for an investigation following initial consideration; (2) not to refer the case to a Fitness to Practise Panel; (3) to issue a warning; or (4) to cease consideration of a case where undertakings are agreed.

8.225 An overwhelming majority agreed with the proposal regarding which decisions could be reviewed.[27] For example, an individual consultee (Lucy Reid) said this would be a "very welcome amendment".

[27] Of the 192 submissions which were received, 43 expressed a view on this proposal: 41 agreed, whilst 2 held equivocal positions.

8.226 The Medical Defence Union argued the power to review should also include "the ability to review a decision to refer a case to a Fitness to Practise Panel". An individual consultee (James Kellock) pointed out that the General Dental Council and the General Optical Council already have a power to review decisions to refer cases to a Fitness to Practise Panel. He said that:

> This is useful in rare cases where further information comes to light and whilst it is true to say a Fitness to Practise Panel can be left to deal with it, surely the better view is that if the referrer no longer thinks the case passes the real prospect test it is unfair on all parties, but especially the registrant, that the weight of proceedings should hang over his head for a further period.

8.227 The Patients Association argued the proposal should include an ability to review the use of mediation or consensual disposal "if they are included in the framework".

8.228 Whilst the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal, it cautioned that "care be taken where a complainant is simply not satisfied with an investigation and purely seeks to prolong [a case] or victimise a registrant".

Provisional Proposal 8-23: Anyone who has an interest in the decision should be able to initiate a review of an investigation decision, including but not limited to the Registrar, registrant, complainant and the Professional Standards Authority.

8.229 A majority agreed that anyone with an interest should be able to initiate a review.[28]

8.230 A number of consultees emphasised that anyone with an interest could request a review, but that the decision would be for the regulator. For example, the Medical and Dental Defence Union of Scotland said that "those with an interest should be able to initiate a review but they should not be able to compel one". The Optical Confederation thought that the "right to initiate a review should remain with the regulator and the registrant".

8.231 The Medical Defence Union agreed on the basis that there is no "automatic right for an interested party to have a review" but rather a right to seek or request a review "because reviews can only be undertaken if specified grounds are met".

8.232 The Professional Standards Authority suggested that employers should specifically be able to initiate a review. UNISON argued that a complainant should not be able to initiate a review "as this is not a complaints process" and the current external scrutiny of decisions by the Professional Standards Authority is sufficient.

8.233 Several consultees pointed out that difficulties may arise in defining who may have an interest in the decision over and above the complainant and the registrant. The Royal Pharmaceutical Society of Great Britain argued that:

[28] Of the 192 submissions which were received, 38 expressed a view on this proposal: 26 agreed, 9 disagreed, whilst 3 held equivocal positions.

> the vagueness of [the] wording "anyone who has an interest" is too overarching and empowering for anyone to request a review just because they are unhappy with the outcome.

8.234 Several consultees were concerned that the current wording of the proposal left open the possibility of the right being abused. The British Chiropractic Association said it "would expect to see firm guidance in relation to parties that constitute 'anyone interested'". The General Osteopathic Council referred to the need for "safeguards to prevent vexatious requests from complainants …, and unmeritorious attempts by registrants to stall the progress" of cases against them.

8.235 The Department of Health also expressed concerns that giving "anyone including the registrant" the ability to initiate a review might be too wide and could potentially include anyone who happened to disagree with the decision.

8.236 The Department of Health, Social Services and Public Safety for Northern Ireland also supported the proposals but also felt that there needs to be "clear terms as to who can initiate a review".

Provisional Proposal 8-24: The grounds for a review of an investigation decision should be that new evidence has come to light which makes review necessary for the protection of the public or the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.

8.237 A large majority agreed with the proposed grounds for a review.[29] For example, the British Pharmaceutical Students' Association thought that the proposal would "ensure fairness is maintained for registrants who have fallen foul of proceedings". The General Optical Council also supported the proposed grounds, which it pointed out reflect its current legislation. The Council also said that it would "support a harmonised approach being adopted to rejecting requests which are based purely on the fact that a complainant does not agree with a decision".

8.238 The General Medical Council argued that the grounds should include that an investigation decision was wrongly decided. It stated:

> To ensure we protect the public effectively we need an ability to review and overturn a decision in those exceptional circumstances where, on review, it appears it was flawed. This is also important in encouraging a culture of learning within the organisation. We currently have such a power.

8.239 The Royal College of Nursing supported narrow criteria for a review which include a requirement that a review is necessary and proportionate. The Optical Federation felt that a "significant" administrative error should be required before a review can take place.

8.240 However, the Professional Standards Authority supported a broader threshold which did not include references to "public protection" or "public interest". Instead it suggested the threshold should be:

[29] Of the 192 submissions which were received, 29 expressed a view on this proposal: 24 agreed, 4 disagreed, whilst 1 held an equivocal position.

> if the new evidence/error is considered to be material enough to raise the real prospect that a decision-maker looking at the matter afresh would reach a different decision to the one that was originally made. We would also add a third ground for a review of an investigation decision, namely where a decision has been made following an incorrect interpretation of the law.

8.241 RadcliffesLeBrasseur argued that the proposed grounds "are too narrow and one sided" and that a review should be initiated "where new information demonstrates that that is in the interests of justice". The Health and Care Professions Council felt that a review should only take place where the *Ladd v Marshall* criteria apply, namely when relevant new evidence becomes available.

8.242 The Nursing and Midwifery Council stated that the statute should define the meaning of "public interest". UNISON argued that there should be definition of "what would be construed as an administrative handling error". The Health and Care Professions Council thought that "the grounds should be provided for within the statute".

Provisional Proposal 8-25: The statute should give the regulators broad rule and regulation-making powers on all aspects of the process for the review of an investigation decision, except those matters specified in provisional proposals 8-22, 8-23 and 8-24.

8.243 The vast majority agreed that the regulators should be given broad rule-making powers.[30] For example, the General Medical Council argued that:

> The volume and nature of the concerns raised will vary considerably between the different regulators and flexibility is needed to ensure we have the flexibility to maintain an efficient and effective process to suit the context within which we work.

8.244 The Scottish Government agreed generally with the proposals but warned that:

> Adequate constraints and safeguards would need to be in place to ensure that such reviews had an objective basis (rather than individual differences of opinion), could be justified and would withstand any test of external scrutiny. This would be necessary to prevent the potential for excessive demands on resources in the event of too many requests for a review being made with the associated impact on costs.

8.245 The Nursing and Midwifery Council agreed with the proposal, but suggested that "a common approach to the drafting of these rules may be beneficial and cost-saving".

[30] Of the 192 submissions which were received, 36 expressed a view on this proposal: 34 agreed, whilst 2 disagreed.

8.246 The Royal Pharmaceutical Society of Great Britain sought had “some reservations” about the proposal. It sought “clarity as to whom, and what internal, and professional consultation, there would be for the designation of the proposed broad powers to make Rules”. It also asked “for assurances that professional opinion will be sought and listened to with such an important area of innovation”.

8.247 Several consultees argued that any right to review must be subject to strict time limits such as two years (Medical Protection Society) or five years (James Kellock), and that the review itself must be subject to timescales. The Professional Standards Authority suggested that the time limit could be “linked to the timing of the discovery of new evidence/administrative error”. It also felt that “the registrant should be invited to comment on the case before the review is undertaken” and the statute should also specify “the nature of any information that is to be published generally and/or disseminated to the parties following any review about its outcome”.

8.248 The General Optical Council argued that the reviewing body must not be the Fitness to Practise Committee “as this would increase cost and administrative burden” but rather an Investigation Committee or Case Examiners. An individual consultee (James Kellock) argued that the review should be conducted by “the same person/body that took the original decision” on the basis of “familiarity with the matter ... consistency of decision-making [and] lower costs”.