June 2021

Regulating healthcare professionals, protecting the public

Consultation response

Link to DHSC consultation doc

1 Do you agree or disagree that regulators should be under a duty to co-operate with the organisations set out above?

Agree.

We fully support the new duty to cooperate, hoping this will lead to improved information sharing and reduced duplication in the professional regulation system, where it is needed. Trust leaders deal with a wide array of regulatory bodies and – while many of these are not tasked with the regulation of particular professional groups – the same principles of proportionality and efficiency should apply here and be factored into formal collaboration mechanisms between regulators (whether they oversee staff or the delivery of services).

The new duty extends cooperation on the part of all professional regulators to "organisations that are concerned with… the employment, education and training of healthcare professionals; and the provision of healthcare services". These parts of the duty are of most relevance to trusts in their roles as employers and providers and we support this inclusion. While NHS Providers and many trusts enjoy positive relationships and existing lines of cooperation with professional regulators, including the GMC, this formalisation should serve to support even greater collaborative working between regulators, providers and systems.

5 Do you agree or disagree that regulators should be able to set their own fees in rules without Privy Council approval?

Agree.

Regulators should be able to set their own fees in rules without Privy Council engagement, particularly given the fact that several (GMC, GDC, GOC, GPhC) already have the power to do so. We believe the current arrangements whereby most of the regulators seek Privy Council approval for fees changes are a prime example of legislation restricting flexibility, including the ability of regulators to adapt to changing circumstances, and any sense of timely policy implementation for the good of patients, professionals and their employers.

6 Do you agree or disagree that regulators should be able to set a longer-term approach to fees?

Agree.

Regulatory autonomy is a vital part of effective regulation, and we support moves to further this. A long-term approach to fees is positive and we support it, but the rationale behind each approach would need to be clearly evidenced with a specific long-term improvement as the ultimate aim. Each such approach must also take into account the costs involved for registrants, as regulated roles must remain attractive career options for applicants.

13 Do you agree or disagree that all regulators should have the power to set:

• standards for the outcomes of education and training which leads to registration or annotation of the register for individual learners;
• standards for providers who deliver courses or programmes of training which lead to registration;
• standards for specific courses or programmes of training which lead to registration;
• additional standards for providers who deliver post-registration courses of programmes of training which lead to annotation of the register; and
• additional standards for specific courses or programmes of training which lead to annotation of the register?

Agree.

We agree with the policy intent behind this proposal, given the limitation placed on some professional regulators at this stage to only set education and training standards for course providers, and the need to better allow regulators – and the system as a whole – to adapt education and training "to the evolving needs of the healthcare environment". As the consultation states, this proposal would enable all regulators to "set specific standards which specify the outcomes that learners should achieve by the end of relevant education and training", alongside having the "option to set additional standards which a provider must meet" if it is to offer certain courses.

We believe regulators, and other stakeholders across the system, need to work together more closely on the design and assurance of healthcare education and training. This will help to ensure ongoing quality which leads to registrants carrying out safe and effective care, but it will also help to create a system of education and training which better reflects and considers changing models of care and the future needs of the workforce linked to these. While many trusts across the country have developed strong partnerships with local healthcare education institutions, there are other areas where universities have been resistant to the changing needs of the healthcare workforce and have been reluctant to embrace alterations to curricula or course design that would help to offer a broader range of opportunities to people interested in careers in the NHS.

This proposal and others outlined within this consultation will not solve this issue by any means, but the greater level of oversight given to regulators should help to promote a more collaborative and flexible approach to the design of healthcare education and training going forward.

14 Do you agree or disagree that all regulators should have the power to approve, refuse, re-approve and withdraw approval of education and training providers, qualifications, courses or programmes of training which lead to registration or annotation of the register?

Agree, as per the answer to question 13.

23 Do you agree or disagree that regulators should be able to set out in rules and guidance their CPD and revalidation requirements?

Agree, with conditions.

We support the introduction of a new power for regulators to set standards for CPD and/or revalidation, however the rules and guidance for professional development activities must, in the case of all regulators, be developed with appropriate collaboration from NHS providers/employers. This position appears to be supported in the government's proposals under paragraph 142, which states "when proposing any changes to their existing rules on CPD and/or revalidation, regulators would be required to consult with employers and other key stakeholders". The consultation is correct to state that "regulators are best placed to determine what registrants need to demonstrate to prove that they remain safe to practice", and that it is "essential for public protection that registrants demonstrate their skills and knowledge are up to date and equip them for the roles that they carry out". CPD is an essential part of ensuring healthcare professionals continue to undertake safe practice.

Regulators, and all stakeholders within the NHS workforce, need to consider the wider context to CPD, not least that it is also a critical element of the employment offer. CPD is undoubtedly seen as a retention tool for trusts, enabling staff from all professions to progress within their careers and feel valued within their organisations and as the driving force behind our national health service.

The importance of CPD to the development, morale, and ultimately retention of staff has been particularly clear in recent years, with a lack of sufficient funding for CPD limiting its provision and reach across the workforce. While trusts have been able to support their staff to undertake the minimum levels of CPD required, training and development must go further. The ability of trusts to provide these opportunities has been limited by an ongoing shortfall in funding, particularly since the national workforce development budget was reduced from £205 million in 2015 to £83 million in 2017 as part of wider cuts to HEE funding.

Trust leaders need to be engaged as they – alongside staff side representatives – are best placed to determine the development needs of the growing and changing healthcare workforce. Targeted investment in workforce development will also play a key part in efforts to improve workforce planning across the wider health and care system, and the work of regulators in this area needs to take this into account.

24 Do you agree or disagree that the regulators should hold a single register which can be divided into parts for each profession they regulate?

Agree.

We agree that the regulators should hold a single register, divided into parts for each profession they regulate. As new roles are developed and rolled out across the NHS it will be important that processes for regulating these new roles are proportionate and streamlined, with existing registers futureproofed to enable the inclusion of new roles.

This is particularly pertinent given the introduction of new legislation in 2021 includes scope for the Secretary of State to introduce professional regulation of senior NHS leaders. Trusts have concerns around the logistics and cost of introducing mandatory professional regulation of managers, and we understand that a voluntary system of professional regulation for managers remains under consideration. However, given the scope of the forthcoming health and care bill, any changes to the broader system of professional regulation should minimise the potential costs of implementing the proposal and ensure that the existing regulatory framework is able to accommodate a new regulator and a new profession. There will also be a need to consider how medical and nursing directors, among others who may also hold clinical registration as well as an executive or non-executive board role, could be managed under the mandatory introduction of professional regulation of managers and how duplication would be avoided.

25 Do you agree or disagree that all regulators should be required to publish the following information about their registrants:

- **Name**
- **Profession**
- **Qualification (this will only be published if the regulator holds this information. For historical reasons not all regulators hold this information about all of their registrants)**
- **Registration number or personal identification number (PIN)**
- **Registration status (any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules/policy made by a regulator)**
- **Registration history**

Agree.

We agree that it would be beneficial to achieve greater consistency across the regulators in their approach to publishing information about registrants, and what information is collected and published. The proposed information seems proportionate. There is likely to be a one-off administrative exercise for regulators which do not currently publish all of the proposed information, and this should be taken into consideration, additionally whether those regulators would need to seek additional consent from registrants to enable this data to be published.

27 Should they be given a discretionary power allowing them to publish specific data about their registrants?

Disagree.

We disagree that regulators should have a discretionary power allowing them to publish specific data about their registrants. The remit surrounding which data can be published should be tightly defined and any discretionary power to publish specific data about registrants would need to be underpinned by a clear rationale for inclusion, subject to external assurance and scrutiny, and be proportionate. For example, it would be helpful to understand further how the use of this power in the Social Worker Regulations directly translates to the health sector, and the Department should set out clearly when it expects this power to be used.

28 Do you agree or disagree that all regulators should be able to annotate their register and that annotations should only be made where they are necessary for the purpose of public protection?

Disagree.

We disagree that all regulators should be able to annotate their register as there is a risk of subjective judgements being included, and a lack of transparency about how decisions to annotate are taken. It is unclear why annotations to the register would be required for public protection if the existing information held by the register was fit for purpose.

Again, it would be helpful to understand what information would be included additional to information already collected by the register, and how this might add value. Where specific information is needed for public protection, safeguards would need to be in place to ensure the threshold for necessity is met, including exploring options for external assurance of decisions made by the regulator.

29 Do you agree or disagree that all of the regulators should be given a permanent emergency registration power?

Agree.

The ability of the GMC, NMC and HCPC to create emergency or 'temporary' registers in March 2020 played a critical supportive role in the healthcare workforce's response to the emerging pandemic. Thousands of additional staff, including recently retired 'returners', have made an invaluable contribution to trust staffing and the wider NHS over the past 16 months.

While the GMC was able to undertake emergency registration without parliamentary approval through existing powers, other regulators were not able to do so and the government's legislation to broaden this power – while providing valuable assurance – delayed the deployment of additional staff into the service. This delay was minor, however we feel the same rules should exist for all regulators in this regard, signalled by the clear consensus on the relevant provisions of the Coronavirus Act last year. We note that the same procedures for the Secretary of State to notify registrars about the occurrence, forthcoming occurrence, or ending of an emergency situation remain in place.

42 Do you agree or disagree that the prescriptive detail on international registration requirements should be removed from legislation?

Agree.

The NHS is heavily reliant on international recruitment, but it is not a straightforward process. The cost of international recruitment can be significant for providers, through visa sponsorship and other employer charges. Many organisations are not able to capitalise on international recruitment due to funding constraints, and also due to the prescriptive nature of a regulatory and administrative process which not all providers have the necessary in-house expertise to navigate. Similarly, there is often an abundance of paperwork which an individual international applicant has to fill out, which is not only off-putting for the applicant but would appear at times to be unnecessary to the role they eventually take on. Streamlining regulation around international registration would be a very positive step in reducing one of many barriers to international recruitment, making it easier for providers to maximise opportunities, and smoother for individuals undertaking the application process.

43 Do you agree or disagree with our proposal that regulators should be given powers to operate a three-step fitness to practise process, covering:

- **1: initial assessment**
- **2: case examiner stage**
- **3: fitness to practise panel stage?**

Agree.

Our view is that changing the fitness to practise process to be less burdensome and prescriptive would be positive for both employers and individual staff members. We expect, and indeed support, a level of standardisation of process in this area, but the current system is too often unfit for purpose. As the GMC set out in an earlier public briefing, "under the current legal framework, we are too often required to investigate allegations even when it's apparent they won't result in regulatory action." This creates additional work and stress for employers, their staff, and regulators, which often leads to no useful outcome. Introducing a process for accepted outcomes in fitness to practice complaints make it possible for unnecessary panel hearings to be avoided, benefitting the individuals, regulators, and employers involved.

We understand that the proposed duties of transparency for regulators will require consultation on regulators' criteria for onward referral in the first stage (initial assessment), before they are implemented. This sits alongside a proposed duty for regulators to assess the proportionality of any new regulatory requirement, procedure or guidance they propose to introduce. This is welcome, as it will be important to make sure these criteria will work for all parties involved in fitness to practise cases.

The proposal to reduce grounds for action to just two areas (lack of competence, and misconduct) has caused concern for the GMC. We are supportive of streamlining this area, but recognise the GMC's concerns that considering health and English language as part of an assessment of competence may inhibit their ability to take proactive steps to address any such issues. We request that this issue is assessed fully before such change is implemented.

We would also request clear guidance on how to use the proposed "full suite of measures to conclude a case at stage two" (case examiner stage), as case examiners will need to be mindful of equalities in discretionary application of these. We firmly welcome the proposal to prohibit regulators from requiring reflective practice material from individuals undergoing fitness to practise investigations. This will help to promote a culture of learning rather than blame in the NHS, which has been proven to help patient safety and staff morale.

Overall, we would agree with a process that allows enough flexibility so that full investigations do not have to be made in circumstances which don't warrant them, and we would welcome the opportunity to comment on individual regulators' proposed criteria for such processes before they are implemented. Proposed duties of transparency for regulators will be helpful in this process.

59 Do you agree or disagree that a registrant should have a further onward right of appeal against a decision not to permit restoration to the register?

Agree.

We agree that registrants should have further onward right of appeal against a decision not to permit restoration to the register. Trusts believe that rehabilitation and right of appeal are fundamental principles of good and fair professional regulation and so we support the proposal to introduce this right of appeal to those who have been denied restoration to the register.

64 Do you agree or disagree with the proposed approach to the regulation of PAs and AAs?

Agree.

The physician associate (PA) workforce makes up a small but highly valued part of the NHS. DHSC notes that there are around 2,100 PAs on the current voluntary register with the workforce projected to grow to 6,000 by the end of 2023. While this is moving in the right direction, there is ample room for more ambition: assuming current national staffing growth trends until 2023 – and discounting the fact that many PAs work in primary care – 6,000 PAs would equate to less than half of one percent of the entire clinical and clinical support trust workforce in England.

We are therefore pleased that this consultation proposes to grant formal regulation of PAs – as well as anaesthesia associates (AAs) – to the GMC, which will be able to assure standards in practice and in the education and training of this workforce. Crucially, regulation will also present trusts with a necessary level of clarity and consistency regarding the role of these professionals within the wider workforce as employers consider desired future skills mix at local and system level. We note the large number of educational institutions offering PA qualifications (35), despite the small size of the workforce, and feel the GMC is well placed to oversee development and a level of standardisation in this area.

Trust leaders consistently report the high value of professionals in 'new roles', who support the work of regulated clinicians and the work of wider multi-disciplinary teams. In particular, trust leaders find that the contribution of PAs in emergency care has been appreciated by senior doctors, nurses and other professionals, who tend to appreciate the flexibility provided by working alongside professionally qualified staff whose efforts allow them to focus on the more challenging and clinically appropriate tasks they are required to manage. In other words, trust leaders feel PAs remove administrative burden and can enable clinicians to work closer to 'the top of their licence'.

There is frustration at the slow rate of growth in this profession and – while we support the overall approach and the detailed elements of regulation for PAs within this consultation – it is important to note that this process started over four years ago with the DHSC consultation in 2017. Some trust leaders have questioned whether the supply of PAs is 'drying up', or these professionals are being de-prioritised as part of the future workforce model.

We do not believe the latter point to be the case and we support HEE's efforts to emphasise a 'more and different' approach to workforce growth in the NHS. However, we urge DHSC, its arms-length bodies, and other government departments to act at a greater pace to truly realise the benefits PAs can bring. For instance, we note the consultation's statement that regulation is a "necessary step towards the longer-term aspiration of extending a form of prescribing responsibilities", and that DHSC is working with key stakeholders "to develop an initial case for extending appropriate prescribing responsibilities to one or both roles".

In 2019, NHS Providers co-signed a statement on PA prescribing rights, alongside the FPA, RCN, BMA and NHS England, seeking to offer clarification on the current legal position and best practice. The statement said "the scope of practice of a PA does not include the ability to supply or prescribe medicines and there is no legal framework to support this. It is therefore best practice that people who are qualified to supply medicines or who are registered prescribers do not use these responsibilities in their PA role." However, all of the organisations involved expressed support for the development of the profession to include prescribing rights in due time, with the statement adding, "it is important that

stakeholders work together to consider the need and appropriateness of supply of medicines and prescribing rights for the profession."

Safety considerations are paramount in the development of prescribing responsibilities and we support the need for further work in this area. However, we would urge all parties involved to avoid the unnecessary delays we've seen to date in bringing forward regulation, particularly given the likelihood of ultimate consensus in this area, and the genuine need for 'more and different' professional groups with greater responsibility across the NHS as we seek to grow the workforce substantially in the coming years.

66 Do you agree or disagree with the transitional arrangements for PAs and AAs set out above?

Agree.

We agree with the transitional arrangements for PAs and AAs described in this consultation as these professionals are brought into statutory regulation. We believe the two-year period for practitioners to transition to a statutory register is reasonable and proportionate, and should not significantly disrupt ongoing practice, or the education and training of these professionals.