RESPONSE TO

LAW COMMISSION CONSULTATION:

REGULATION OF HEALTHCARE PROFESSIONALS

May 2012

Introduction

As the UK charity for patient safety and justice, Action against Medical Accidents (AvMA) welcomes the opportunity to respond to this important consultation. AvMA has always given high priority to the regulation of health professionals as one of the key elements of protecting patients and improving patient safety. AvMA has over 30 years' experience of working with health professional regulators themselves and the patients and families who have suffered as a result of lapses in health professional standards, and who have experience of the fitness to practise procedures. AvMA is the only charity which runs a specialist independent advice service which is geared to help and support people in these circumstances. AvMA played an active role in several of the inquiries into scandals involving health professionals including the Shipman Inquiry, and in the Department of Health work to recommend how to implement the recommendations stemming from those inquiries and the White Paper *Trust Assurance and Safety: Health Professional Regulation in the 21st Century.*

Overview

AvMA welcomes the bulk of the recommendations proposed by the Law Commission but believes that as they stand the recommendations do not go far enough to deliver a system of regulation which is fully fit for purpose. In particular, recommendations do not sufficiently address the massive inconsistency between regulators or provide a framework of accountability which will improve the quality of regulators' work, ensure fairness and safety, and increase public confidence in the system. This would be a missed opportunity to make much needed and long overdue improvements and may even lead to more, not less inconsistency. We have limited our recommendations to the areas which we do not think are adequately addressed or addressed at all by the Law Commission in its consultation, and need to be.

Recommendations

1. Emphasis on patient safety

The regulators' rules and fitness to practise procedures in particular need to be rewritten so that they are consistent with the primary purpose of health professional regulation – to protect patients and the public. The five year rule used by the GMC is a prime example of how rules do not currently put patient safety first or uphold essential professional standards. If there are serious allegations or concerns about a health professional calling into question their fitness to practise, they should always be investigated. However, we have also seen other examples of regulators' rules militating against patient safety. For example in one case we were involved in a doctor who the GMC itself had grave concerns about had his fitness to practice case dismissed because of an earlier flaw in the process (the GMC's first investigation was bungled). The doctor was allowed to continue to practise, putting patients at unnecessary risk, because the GMC was unable to act because of a technicality. The various regulators' rules have become arcane and out of date due to the ad hoc

changes that have been made over the years. The new rules should be re-written to ensure that patient safety considerations trump any other. This should be the litmus test as to whether any new statutory framework is fit for purpose.

2. Consistency between regulators

A phrase which appears repeatedly in the document is *"the regulators would be given broad powers".* We agree that the current system of having to go through a parliamentary process to make simple changes to the regulators' rules is bureaucratic and cumbersome and should be made more flexible. However simply giving regulators broad powers is a recipe for even more inconsistency. All the regulators should be bound by overarching regulations which guarantee a consistent approach. It is absurd for example, that the GMC applies its own 'five year rule' which protects most doctors from investigation if allegations are more than five years old. This rule is (quite rightly) not applied to other professions such as nurses.

3. Safeguards and Accountability

No system of regulation or individual regulator will be perfect. Mistakes can and are made by regulators and will be in the future. The system should help minimise instances of this and put in place safeguards to ensure that when mistakes are made they can be addressed.

Whilst we welcome the recommendation that all regulators should be able to review decisions made early in the fitness to practise procedures themselves (for example decisions not to investigate), this does not go far enough. There should be a right for makers of referrals / those that have raised concerns about health professionals to refer the case to the CHRE for review. The CHRE should have the power to challenge such decisions by asking the regulator to review the decision themselves or, ultimately to challenge the decision in the courts. It is already well established that some fitness to practise determinations need to be challenged by CHRE. If this is needed when regulators have had a full investigation and followed the fitness to practise cases, it stands to reason that more mistakes will be made earlier in the process involving far more cases. It is far more likely that a dangerous health professional will slip through the net at this stage than after an investigation.

The CHRE's role as a 'regulator of regulators' should be strengthened, including its role in monitoring the performance of regulators and investigating complaints about them which have not been resolved locally.

We see these safeguards as essential if public confidence in the system is to be improved.

4. Indemnity for health professionals should be statutory requirement

The new statutory regulations should require regulators to establish that health professionals have full, appropriate indemnity cover before accepting registration or reaccrediting them. If a registered health professional causes harm to a patient and is found not to have sufficient indemnity, the regulator should be required to compensate the patient. It is unacceptable that a patient injured by a registered health professional should not be able to receive redress. Regulators should take responsibility for ensuring this does not happen.

5. "Consensual Disposal" of Fitness to Practise cases should be tightly defined

Dealing with fitness to practise issues without a full hearing makes sense but only if the process is fully transparent and robust. Current proposals by the GMC to meet in private with doctors to 'discuss' the proposed sanction and seek their agreement would lead in effect to plea bargaining or at least the perception of it. This would greatly damage public confidence in the system. Consensual disposal should only be allowed if the health professional accepts the factual findings of an investigation and that the regulator has complete discretion to apply the sanction it sees fit. The sanction should be kept entirely separate from the investigation and other discussions.

6. "Voluntary Erasure" should be tightly defined

The new arrangements should make it impossible for registered health professionals to remove themselves from a register so as to avoid investigation. Even where a health professional has already left the register, regulators should have a power (and a duty) to investigate and record findings to mitigate the risk of that health professional re-joining the register at a later stage without the concerns having been addressed, or the health professional registering in a different country without the concerns coming to light.

7. The 'Tackling Concerns Locally' recommendations should be implemented in full

The world of regulation does not exist in isolation, and the effectiveness of regulators is determined to a large extent by the context and external environment in which they work. We therefore urge the Law Commission to look beyond a narrow focus on the regulators themselves and to stress that no matter what legal changes are recommended and adopted, health professional regulation may still fail in its primary purpose if wider issues are not addressed. An expert multi-agency group convened by the Department of Health called "Tackling Concerns Locally" was set up along with a number of others to make detailed recommendations for improving health professional regulation in line with the White Paper *Trust Assurance and Safety* and following the various health professional scandals and enquiries. The group reported in March 2009 but many of its recommendations have still not been implemented.

This means that the same problems, gaps and risks that existed then and about which there was multi-agency expert agreement still exist. There has been no formal explanation as to why this is the case and no plan announced about how these issues are to be addressed. All of the group's recommendations need to be addressed, but here we deal with two that we believe are particular priorities:

a) **Duty upon healthcare employers to co-operate with key stakeholders and to share information**. This was a central and essential theme of the group's report and the Shipman and other inquiries had also called for the issue to be addressed. At the moment, there is no statutory requirement on employers (including, for example, GP or dentist practices) to share information about concerns or indicators of poor practice with potential new employers or other key stakeholders such as the regulators themselves. This means that bad health professionals can simply be passed on to another employer without issues being addressed and employers not notifying the regulator so that they can investigate and use their powers to protect patients. We gave the following example to the Shipman Inquiry, which led to a recommendation being made on this issue. A GP can have a multitude of serious complaints made against him and even a series of clinical negligence cases where he is found to have been negligent, without the information ever coming to the notice of the PCT (or in future, the Clinical Commissioning Group) or the GMC.

   In March 2010 the Department of Health consulted on the proposed *Health Care Workers (Duty of Cooperation) Regulations*, which were designed to tackle these issues. The Department of Health finally responded in February 2012 saying that it was not going ahead with the regulations, without any further consultation. No credible rationale was given for this decision. The implication that the regulations may not be needed any more because of proposals for revalidation of doctors and the introduction of Responsible Officers is completely false. All stakeholders including the Department of Health knew about revalidation and Responsible Officers when they made the recommendations in *Tackling Concerns Locally* and when the Department proposed the new regulations. In any event, Responsible Officers only relate to doctors. Continued failure to address these issues will continue to undermine the capacity of the regulators to protect patients and therefore puts patients at risk.

b) **Independent Advice and Support for members of the public in raising concerns.** There is currently no service funded in the UK to help members of the public who may need to report serious concerns about a health professional to a regulator. This gap was identified by the Shipman Inquiry and the *Tackling Concerns Locally* group reaffirmed the importance of bridging this gap and made explicit recommendations about it (see recommendation 2, main report and Recommendation 12, Clinical

Governance sub-group report). Without these measures many members of the public will either be too intimidated by the regulatory process to bring concerns before a regulator; may not be able to articulate their concerns in a way that regulators appreciate the seriousness; may not be able to challenge erroneous assumptions or decisions made by a regulator; and may withdraw their co-operation with a fitness to practice process due to the stress of coping with it without independent support. This all means that concerns about dangerous health professionals may not come to light and other patient s left at risk

8. Address gaps in regulation due to EU Directives

The new arrangements should address the problems resulting from the freedom accorded to EEA registered health professionals to practise in the UK without the normal checks and balances which the regulators apply to all other health professionals from overseas, including checks on competence and English language skill. Health professionals from the EEA area make up an increasing proportion of the healthcare community in the UK and without closing these gaps a large number of health professionals will simply not be covered by the system of regulation which the Law Commission is considering.

Action against Medical Accidents, May 2012