



community  
research

# **The patient and public perspective on future fitness to practise processes**

**May 2020**

*Bringing the voices of communities into the heart of organisations*

**All interpretation and opinion in this report is that of the authors alone and does not necessarily reflect those of the Professional Standards Authority.**

**The authors would like to thank all participants for their contributions to this research.**

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# 1. Executive summary

## 1.1 Background and objectives

As part of wider reforms to the legislative framework for professional regulation, the Government is proposing to extend powers to all of the health and care professions' regulators, allowing them to dispose of any fitness to practise cases – including the most serious – at the end of the investigation without a hearing<sup>1</sup>. The Professional Standards Authority, which is independent of the regulators, professionals and Government, can challenge the decisions made at hearings if they are deemed to be insufficient to protect the public. The Government has yet to decide whether or how the Authority might be able to contest outcomes agreed through the consensual disposal process<sup>2</sup> that do not protect the public.

Whilst the Authority is supportive of moves away from an adversarial approach to Fitness to Practise, it has also highlighted the potential impact on public protection and public confidence of a more consensual model if certain safeguards are not in place. It has, therefore, commissioned a programme of qualitative research in order to further explore this issue. The research objectives were to explore the following:

- The potential impact of the emerging future approach to fitness to practise on public confidence.
- How complainants would wish to be involved in the emerging future fitness to practise model.
- Views on oversight of the new arrangements.

The approach comprised group discussions (two online and three face to face) and 13 individual depth interviews (by telephone). This gave geographical flexibility and enabled researchers to engage with members of the public, patients/service users, carers and complainants.

## 1.2 Key findings

### *The context*

Typically participants based their confidence in health professionals on their own direct experience with individual health professionals. If they had had generally positive experiences, they extrapolated this to a more generalised trust.

Professional wrongdoing was not, for most, top of mind with only a small number of reports breaking through – for example the breast surgeon, Ian

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<sup>1</sup> The proposed model is broadly the approach made available to Social Work England, which took over responsibility for the regulation of social workers in England from December 2019.

<sup>2</sup> This refers to cases disposed of consensually at the end of the investigation stage through a sanction imposed by the regulator, and accepted by the registrant. A hearing would still be held if there was a disagreement on the facts of the case, or on the sanction.

Paterson and Harold Shipman. However, these cases were felt to be the exception rather than the rule, with the professionals involved tending to be dismissed as 'bad apples.'

There was little knowledge of the various organisations involved in health and social care regulation or of how health and social care professionals are held to account. Other than the thirteen participants who had made a complaint to a regulator, few were able to name any of the ten health and social care regulators overseen by the Authority.

### ***Overall response to the proposed changes***

Participants were given information about the current fitness to practise process and how it may change in future through an explanation, handouts and a five-minute video.

Although there was a sense from some participants that the fitness to practise process does need to evolve and move with the times, the overall response to the described changes was often a mix of:

- Scepticism as to why a new model was being proposed.
- Agreement with the general move to reduce the number of hearings given associated benefits relating to reduced case length and stress for all involved.
- Concern about how the new model would be implemented and overseen, including:
  - What is the real driver for the change? There was some underlying concern that the changes were being introduced in order to cut costs, reduce a backlog of cases or to massage case numbers.
  - Will regulators be able to manage the changes efficiently?
  - Will regulators be less stringent in their processes to try to ensure that more cases are disposed of consensually?
  - Will any changes be carefully monitored and evaluated to ensure that there are no unanticipated adverse implications (or unintended consequences)? Will the changes be piloted in some way?

A key caveat was that the changes to the fitness to practise process are only acceptable if the public can be confident in the process as a whole. Ensuring the robustness of the process, prior to any consensual disposal, becomes even more important if there are fewer panel hearings and reduced levels of oversight.

### ***Response to the proposed reduction in hearings***

Overall, the proposals to reduce the use of panel hearings during fitness to practise processes were welcomed (with some caveats). The changes were felt to make intuitive sense in that they were likely to reduce associated costs, the time to dispose of cases and be less stressful for all involved parties.

An immediate question was whether patients or service users will still have a voice in the process. However, this did not automatically translate into the call to have a voice at a hearing. In fact, the fact that complainants would not need to give evidence at a panel hearing was seen as one of the key advantages of the emerging model. There was widespread concern that a panel hearing could be daunting for witnesses and could mean ultimately that complaints are not pursued, having a negative impact on the protection of the public/patient safety overall.

The increased use of consensual disposal was assumed to equate to the speedier disposal of cases. This was perceived to be a benefit in itself in that the complainant(s) and the registrant would have a quicker resolution and not have the stress and anxiety associated with a drawn-out process. Reducing the average length of cases should also ensure that the public is protected faster.

However, there were several reservations associated with the new system which participants felt needed to be addressed:

- If a case does not go to a hearing, will this equate to a less thorough interrogation of the evidence? If registrants and witnesses are not cross-examined in public, will regulators still be able to ascertain the truth?
- What do the changes mean for the robustness, impartiality and transparency of the process?
- What information will be made available to the public and the complainant?
- Will the fact that decisions are being made 'behind closed doors' influence outcomes in any way?
- Will wider patterns or systemic issues still be identified?
- Will registrants feel pressurised into accepting a sanction in order to avoid the stress and uncertainty involved in a panel hearing?

### ***Response to proposed changes to oversight***

A minority of participants felt that the original decision made by the health regulator should stand, given the time and stress associated with a hearing. A small number of participants also wondered if the changes would have a positive impact on regulators i.e. that they would become more accountable and scrupulous in their decision making as a result.

Overall, the overwhelming majority of participants felt that independent oversight should be retained and there was a clear need for 'checks and balances' within the system. They felt that there were inherent risks with a simultaneous move to a reduction in the number of hearings and a corresponding reduction in scrutiny. Whilst participants were unsure if the individual regulators would actually favour registrants, there was certainly a fairly widespread assumption that this was a possibility. Some wondered if regulators would be tempted to be more lenient with registrants in order to ensure that more cases are agreed and, therefore, avoid an expensive and lengthy hearing or if unconscious bias would come into play. Particular concerns were expressed about a small number of people (sitting on Investigating Committees or as Case Examiners) making decisions on cases in private with

no further oversight. They felt that there was a need to retain greater scrutiny of consensual disposal cases by an independent organisation to ensure that the process is impartial (and is seen to be). Some viewed the Authority's current role as a safety net and struggled to understand the thinking behind the changes.

Participants also advised a cautious, evidence-based approach to any changes to the fitness to practise model. There was a strong call for any changes to the process to be carefully managed, monitored and, ideally, piloted.

## 2. Introduction and approach

### 2.1 Background

The purpose of the ten health and social care professions' regulators is:

- to protect the public.
- to maintain public confidence in the profession and/or.
- to uphold proper standards of conduct and behaviour.

As part of their role regulators can take action when they believe a health or social care professional may be putting the safety of patients at risk. They can also act to maintain public confidence in the profession and to uphold proper standards of conduct and behaviour. Their role is not to punish professionals for having done something wrong but to ensure they are fit to practise.

As things stand, all ten health and care regulators in the UK have their own separate legislation underpinning their fitness to practise frameworks and this results in different processes. However, for the most part, the more serious cases are generally referred to formal hearings in front of fitness to practise committees. The Professional Standards Authority, which is independent of the regulators, professionals and Government can challenge the decisions made by these committees if they are insufficient to protect the public, as defined in the three bullet points above.

Some of the regulators can also dispose of cases consensually at the investigation stage through undertakings agreed with the registrant. Under this process, case examiners, who are employees of the regulator, agree with the registrant that they will practise under certain conditions which, if met, should ensure the registrant is fit to practise. A hearing is still held if there is disagreement on the facts of the case. The Professional Standards Authority cannot challenge these decisions.

As part of wider reforms to the legislative framework for professional regulation, the Government is proposing to extend such case examiner powers to all of the regulators, allowing them to dispose of any cases – including the most serious – at the end of the investigation stage, without a hearing, by looking at evidence on paper, and in private. A hearing would, however, be held if the registrant involved disagrees with the facts of the case or the proposed sanction. Proposals are still being developed and there may also be a mechanism for holding a hearing in other specific circumstances.

This approach to consensual disposal marks a departure from the current model of undertakings agreed by case examiners, because undertakings are restricted to decisions where the public can be protected through what are effectively conditions on registration, rather than suspension or removal. The proposed model is broadly the approach which is available to the new regulator, Social Work England.



The Authority is supportive of moves away from an adversarial approach to Fitness to Practise. It has also highlighted the potential impact on public protection and public confidence of a more consensual model if certain safeguards are not in place. The Government has yet to decide whether or how the Authority might be able to contest decisions made through the consensual disposal process that do not protect the public.

## 2.2 Objectives

This research was commissioned to:

- Explore with the public the potential impact of the emerging future approach to fitness to practise on public confidence.
- Explore with patients, service users and carers how they would wish to be involved in the emerging future fitness to practise model.
- Explore with participants their views on oversight of the new arrangements.

## 2.3 Methodology

### *Overview of the approach*

The approach comprised group discussions (online and face to face) and individual depth interviews (by telephone). This gave geographical flexibility and enabled researchers to meet the varied needs of the public, patients, carers and complainants. In total 45 members of the public were engaged through:

- 3 x face to face group discussions.
- 2 x online group discussions.
- 13 in-depth telephone interviews.

A range of stimulus was used to educate participants and explore the complexity of the fitness to practise process. This can be found in Appendix 10.2.

### *Face to face and online group discussions*

Face to face group discussions were held in locations in England and Wales, whereas the online group discussions comprised participants from across the UK.

- All groups involved 6-7 participants.
- Face to face groups were 2 hours in duration and took place in London, Leicester and Cardiff.
- Online group discussions took place over a one-week period with participants logging in daily to view new questions and provide responses.

An overview of the sample structure is outlined below:

	Location	Type of group
Face to face group discussions	Leicester	General public (18-45 years) Without extensive experience of health and care professions and who have not considered complaining about a health or care professional
	Cardiff	General public (46-75 years) Without extensive experience of health and care professions and who have not considered complaining about a health or care professional
	London	Those who have considered complaining (24-65 years) With extensive experience of health or social care professions often due to the presence of a long-term condition or disability
Online groups	Nationwide (inc. NI and Scotland)	Those who have considered complaining (24-65 years) With extensive experience of health or social care professions often due to the presence of a long-term condition or disability
	Nationwide (inc. NI and Scotland)	Carers (19-68 years)

### ***In-depth telephone interviews with complainants***

A total of thirteen 45-minute in-depth telephone interviews were conducted with participants from across the UK who had made a complaint to a health or care professions' regulator within the previous 2-4 years. This included:

- 5 x complaints to the GDC
- 1 x complaint to the HCPC
- 4 x complaints to the GMC
- 3 x complaints to the NMC

Although this does not represent all regulators it is reflective of the volume of complaints received by regulators in 2016<sup>3</sup>.

Given that there are a number of difficulties in identifying and achieving interviews with this audience, there were no quotas set on whether or not the complaint passed the regulators' thresholds for investigation or, if it did, how the case was disposed of. However, interviews were achieved with complainants who had experienced various stages of the process, including two who had personally attended a hearing and one whose case had been disposed of with undertakings. Further details are provided in Appendix 10.1.

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<sup>3</sup> [https://www.gmc-uk.org/-/media/documents/uk-health-regulator-comparative-report-final-220217\\_pdf-73538031.pdf](https://www.gmc-uk.org/-/media/documents/uk-health-regulator-comparative-report-final-220217_pdf-73538031.pdf)

### ***Fieldwork process***

All research was conducted between 11<sup>th</sup> February and 3<sup>rd</sup> March 2020.

The group discussion and in-depth interviews followed a semi-structured guide in order to allow participants to elaborate on and discuss their views and perceptions freely. All fieldwork was facilitated by Community Research and was audio recorded and transcribed. The discussion guides used are provided in Appendix 10.2 along with all the stimulus used to explain the fitness to practise process and potential changes to it.

### **2.2 Notes on reading this report**

It is important to note that qualitative research is not intended to be statistically reliable and, as such, does not permit conclusions to be drawn about the extent to which something is true for the wider population.

Throughout the report, quotes have been included to illustrate particular viewpoints. It is important to remember that the views expressed do not always represent the views of all those who participated. In general, however, quotes have been included to illustrate where there was particular strength of feeling about a topic.

### 3. The context

#### Section summary:

- **Confidence in health and care professionals** is driven by personal experience rather than any real knowledge and understanding of regulation. However, there is an assumption that there is some form of regulation of all professionals.
- With the exception of participants who had raised a concern with a regulator, **few could name** any of the individual regulators.

#### 3.1 Levels of confidence in health and social care professionals

##### *General public (who did not have extensive experience of health and social care and had not considered raising a complaint)*

There was a relatively high level of confidence in health professionals across this sample. Typically participants based this confidence in health professionals on their own direct experiences with individual health professionals. If they had had generally positive experiences, they extrapolated this to a more generalised trust. They further justified this trust through the presumption that working in the health sector is a vocation and professionals feel a duty of care to patients and that they are highly qualified and highly trained individuals.

*"I have never had reason to believe otherwise, all past experience leads me to believe and be confident in the health and social services. I trust in the process and intelligence required to be working in these professions as a general rule. Though I know systems are stretched and sometimes fail, generally I am confident that they protect patients based on personal experience."*(General public/patients, Leicester)

*"I just have total confidence. But then I've never ever needed social care and I've not had any long-term illnesses, so I understand people that have that would probably have different views, different experiences."*(General public/patients, Cardiff)

##### *Those with extensive experience of health and social care who had considered raising a complaint*

However, those having more frequent contact or experience of the health and social care sector and who had considered raising a complaint typically had lower levels of confidence overall, again attributed to their own individual experience.

*"I've had cervical cancer, currently going through colon cancer and I've had several diagnoses been wrong about that as well. So, it's not really left me with much confidence at all."*(Patients/service users who have considered complaining, London)

The lower levels of confidence in health and care professionals were generally driven by experiences of:

- Misdiagnosis and missed diagnosis.
- Unprofessional behaviour.
- Conflicting advice.
- Inconsistent assessments (by social workers).

### **Carers**

The carers' perspectives were more mixed, with some having relatively high levels of confidence and some displaying low levels of confidence. Some individuals could see both perspectives simultaneously, based on their dual experience; as a patient and as an individual with extensive experience of health and care professionals (through their caring role).

*"I have every confidence if it's myself who is the patient. My conditions are well known and it's just simple treatment. But when it comes down to my wife and her symptoms and treatments I have no confidence. My wife suffers with quite a few conditions and one or two of them are quite rare so I find that there is a lack of knowledge with some hospitals". (Carer, England)*

### **3.2 Awareness of media stories**

Professional wrongdoing is not, for most, top of mind. Some reports of wrongdoing do break through – for example, participants at the face to face groups all mentioned the recently publicised case<sup>4</sup> involving the breast surgeon, Ian Paterson. There were also some mentions of the Shipman case in spite of the fact it was decades ago. However, these cases were felt to be the exception rather than the rule, with the professionals involved tending to be dismissed as 'bad apples.'

*"The only real case that I can understand or have any knowledge of is Dr Harold Shipman and even then the warning signs were there but weren't followed." (Carer, England)*

### **3.3 Empathy for professionals**

There was evident concern for health and social care professionals who were felt to be doing the best they could in challenging, pressurised settings. Resource constraints were widely acknowledged. Throughout the discussions, participants demonstrated empathy with registrants. They frequently tried to put themselves into the shoes of professionals and consider the implications of any changes to fitness to practise processes from their assumed perspective (as well as from the viewpoint of the patient). Participants spontaneously mentioned concern about professionals losing their livelihoods if they are struck off.

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<sup>4</sup><https://www.theguardian.com/society/2020/feb/04/ian-paterson-inquiry-culture-of-denial-allowed-rogue-breast-surgery>

*"Personally, I've got a good level of confidence but I know the health service is battling against quite a lot as well so they do the best they can. You can't always be perfect."* (General public/patients, Leicester)

*"They're under pressure, they're understaffed, they're underpaid so, all things considered, they're humans, they're going to make mistakes and, unfortunately, because of the position they're in, it's more significant. Whereas if you're doing an office job and you make a mistake, no big deal."* (Patients/service users who have considered complaining, London)

*"On the whole I am confident with individuals, I also recognise that health care professionals are only human and can make mistakes or have an off day, the thing that I do not have confidence in is the system as a whole with lack of resources and accountability."* (Patient/service user who has considered complaining, Northern Ireland)

### **3.4 Awareness of and confidence in regulation**

In terms of their awareness of how health and social care professionals are regulated, participants assume that they are regulated by a governing body, much in the same way as other professions (for example, police officers, teachers or financial advisors). However, there was little knowledge of the various organisations involved in health and social care regulation. Other than the thirteen participants who had made a complaint to a regulator, few were able to name any of the ten health and social care regulators overseen by the Authority.

*"It depends on the professional body, so GPs, midwives and social workers have all got professional bodies. Social workers are also held to account by the public ombudsman, aren't they?"* (General public/patients, Cardiff)

*"Just saying something out loud, Care Quality Commission, but I'm not sure if they're a regulatory body."* (Patients/service users who have considered complaining, London)

Beyond this, few participants, aside from those who had direct experience of the fitness to practise process, felt confident they knew how health professionals are held to account, or anything about the potential sanctions that they could face in the case of wrongdoing. The term 'being struck off' was widely known and many participants were aware that it equated to the most severe sanction. Participants associated being struck off with the health and social care professional no longer being able to practise but were not confident about the details i.e. what the professional was being struck off from exactly or whether this was a permanent measure.

*"You see things on the news occasionally, 'doctor struck off for doing something or other', but generally fairly heinous offences or whatever, they're not relatively minor things. So, standards, small sort of everyday type sanctions, no idea whatsoever."* (Complainant 13, Scotland)

This low level of awareness has been found in much other research conducted on behalf of health regulators in the past, including for example, recent research on public confidence conducted for the GMC<sup>5</sup>.

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<sup>5</sup>[https://www.gmc-uk.org/-/media/documents/promoting-and-maintaining-public-confidence-in-the-medical-profession---final-report\\_pdf-78718694.pdf](https://www.gmc-uk.org/-/media/documents/promoting-and-maintaining-public-confidence-in-the-medical-profession---final-report_pdf-78718694.pdf)

## 4. Overall response to the emerging changes

### Section summary:

<p><b>Scepticism</b> about motives</p> <ul style="list-style-type: none"><li>• The extent to which the need to cut cost is driving or influencing the changes.</li><li>• Is it an attempt to reduce the backlog of cases or 'massage the figures'?</li></ul>	<p><b>Agreement</b> with the general principle</p> <ul style="list-style-type: none"><li>• Reduced number of hearings is initially welcomed – a 'daunting' element of the process has been removed.</li></ul>	<p><b>Concern</b> about implementation, monitoring and accountability</p> <ul style="list-style-type: none"><li>• Questions raised about the robustness of the emerging model.</li></ul>
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### 4.1 Information provision to participants

Participants were given information about the current fitness to practise process and how it may change in future. A copy of this stimulus material is provided in Appendix 10.2. In summary, it comprised the following:

- Information on the Authority and the ten health and social care regulators (Handout A).
- Information on the purpose of the regulators and their role in relation to fitness to practise, including available sanctions (Handout B).
- A process flowchart outlining the current process and possible disposal routes (Handout C). Participants were informed that this illustrated a typical process but that the processes of the individual regulators differed slightly.
- A process flowchart outlining the possible future process, with key changes highlighted (Handout D). This highlighted the move to a consensual disposal process<sup>6</sup>.
- A video which describes the purpose and format of a panel hearing<sup>7</sup>.
- Several different scenarios which outlined possible outcomes of fitness to practise cases under the existing and the emerging models. These were developed in collaboration with the Authority in order to help bring some of the issues for discussion to life. These were used to help prompt discussions once the spontaneous response had been explored.

In addition, the following points in relation to fitness to practise were stressed by the facilitator:

- There are lots of different routes, including local resolution, for making a complaint about a professional or the service they have provided, and they all serve different purposes.
- Fitness to practise is not intended to punish but to ensure that healthcare professionals/social workers are fit to practise. It is not about providing

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<sup>6</sup> This refers to cases disposed of consensually at the end of the investigation stage through a sanction imposed by the regulator, and accepted by the registrant. A hearing would still be held if there was a disagreement on the facts of the case, or on the sanction.

<sup>7</sup> <https://www.youtube.com/watch?v=C6Ph0tDEByA>



redress or punishment for their past actions. Instead, the three aims of fitness to practise are:

- Protecting the public.
- Maintaining public confidence in the professions.
- Upholding professional standards.
- The complainant is not central to the process, and not a party to the proceedings. The information they provide is used to build a case against the registrant, which means that they become a witness, rather than a complainant.

#### 4.2 The response to the changes overall

Although there was a sense from some participants that the fitness to practise process does need to evolve and move with the times, the overall response to the described changes was often a mix of:

- Scepticism as to why a new model was being proposed.
- Agreement with the general move to reduce the number of hearings, given associated benefits relating to reduced case length and stress for all involved.
- Concern about how the new model would be implemented and overseen.

##### *A sense of scepticism*

Participants immediately queried the rationale for the changes, with some assuming that there was a negative driver rather than a positive one.

- Is the **need to cut costs driving or influencing the changes?**
  - Some were sceptical about the changes because they felt that regulators wanted to reduce costs (or reduce a backlog of cases). They were concerned that cases may not be thoroughly dealt with because cost-cutting measures are being prioritised.

*"Yeah, it just seems to me like they're obviously thinking about cost at the moment. To bring this into effect they're obviously thinking about how they can save money, less cases going to court or getting to that stage, maybe they can just scrap a few of them."* (Patients/service users who have considered complaining, London)

- Others were more positive about the potential to reduce costs as they felt that the money could be better spent (notwithstanding the fact that some were under the misapprehension that the cost savings would be passed on to the NHS and could be directed to improve patient care).

*"Because the cost effectiveness of trying to free up money allows more money to go into the NHS, which is the most important thing."* (General public/patients, Cardiff)

- **What is the real driver for changes if not costs?** Some participants queried the real motivation for the changes, with some speculation that it was an attempt to massage fitness to practise numbers.

*"I get the impression that this will suit the health professionals a lot more than the complainant. I also have the view that changing this process will make it look like the total number of complaints has lowered, due to the fact that they don't make it to hearing stage and are recorded differently."* (Patients/service user who has considered complaining, Northern Ireland)

*"My concern is that the Government uses the valid reason of stress caused to those involved so as to be able to hold less hearings.....All I'm trying to say is that this a very delicate thing to deal with and the reasoning behind any changes should be explicitly explained."* (Patient/service user who has considered complaining, England)

### ***Agreement with the general move to reduce the number of hearings***

Overall, the proposals to reduce the use of panel hearings during fitness to practise processes were welcomed (with some caveats primarily relating to reassurance about the robustness of the process and transparency). The changes were felt to make intuitive sense in that they were likely to reduce associated costs, the time to dispose of cases and be less stressful for all involved parties.

*"I think, if he [the registrant] was suspended without the hearing, I'd be happy. Because, again, I know I keep saying the same thing, I did find the whole thing quite daunting and I think you've got the dentist's barrister sort of fighting against you, he was only doing his job, but that wasn't very pleasant."* (Complainant 3, England)

*"I think that sounds very sensible. It sounds sort of like pleading guilty in a court of law kind of thing. If you plead innocent then they have to prove it and you have to go through a whole case that takes years and lots of stuff involved but, if the practitioner can put their hands up and say "alright, fair enough, I've made a mistake in this" and can therefore shortcut the entire process and make everything happen much quicker then, off the top of my head, I don't see a downside to that."* (Complainant 13, Scotland)

### ***Concerns about implementation, monitoring and oversight***

Participants had a number of practical concerns about the changes, including:

- **Will the regulators be able to manage the changes,** and have they factored in the need to dedicate additional resources to consensual disposal? There was an assumption that a different skillset may be required for agreeing cases, than for panel hearings.

- **Will regulators be less stringent in their processes to try to ensure that more cases are disposed of consensually?** This point links back to clarity over the drivers for the process.

*"So how are they going to do that, how is that going to be implemented to actually accept more at that stage? Are they going to try and negotiate better at that stage, or are they trying to be less stringent to get that accepted?"* (General public/patients, Leicester)

- **Will any changes be carefully monitored and evaluated** to ensure that there are no unanticipated adverse implications (or unintended consequences)?
  - Will the changes be piloted in some way?

*"As in every process if everything has been trialled and looked at in detail before implementation then you would sincerely hope that any drawbacks would be dealt with immediately."* (Patient/service user who has considered complaining, Scotland)

*"It's like everything, like we were saying how they're monitored, there's annual appraisals. I presume they'd have to have regular assessments of how this is going, whether it's performing right or not."* (Patients/service users who have considered complaining, London)

- Some felt that the fact that it was a new system meant that some form of oversight is more important than ever.

### ***Changes are only acceptable if the process leading up to disposal is robust***

There was also the caveat that the changes to the fitness to practise process are only acceptable if the public can be **confident in the process overall**. Ensuring the robustness of the process prior to any consensual disposal, becomes even more important if there are fewer panel hearings and reduced levels of oversight.

- Participants queried the **triage system** and wanted to be sure that those involved would have received adequate training to do their jobs.
  - There was a presumption by some that more than one person would be involved at this stage so that checks and balances were in place.

*"There are too many hearings, aren't there?... Some things are so trivial that they could be dealt with in a different way, I absolutely agree with that. I think it's just got to be at the triage side and the people looking at the individual cases, it's got to be pretty airtight."* (Complainant 6, England)

- Some wanted reassurance that the process would identify patterns in the data.

*"It's all those individual complaints that add up to a bigger picture and sometimes they find the bigger picture by starting with one individual's complaint as well."*(General public/patients, Cardiff)

- Similarly, participants wanted reassurance about the **robustness of the investigation and decision-making stages**. In particular:
  - They were positive about the involvement of lay people in Investigating Committees or as Case Examiners. This was important particularly given some reservations about potential bias of regulators in favour of registrants.
  - However, some queried the process and particularly whether the Committees or Case Examiners met in person to discuss the cases. They felt that a face to face meeting would mean that the issues were discussed more fully.

*"That's not good, they need to be together really when they're going through it. I did read that about the two case examiners, and I thought that's better, at least there's two, two opinions, two voices really, looking at that information then rather than just one. But they shouldn't be apart because, you know when you're apart, you have different views, you put it together and the view's not always the same. Whereas if you're together you look at something and have a discussion. So, I think they've got to be together if it's two handlers."*(Complainant 4, England)

- Others were concerned about the decision-making process for case examiners querying the following:
  - If one can persuade the other to their way of thinking.
  - Do they reach their conclusions independently first?
  - Who adjudicates (i.e. does it get referred to a panel if they don't agree)?
  - How impartial are they?

*"I feel like they could be easily influenced by each other's opinion on things, and it's also difficult because, if you get a 50/50 split, or someone interprets evidence in a particular way and someone interprets it in another way. And I think people are definitely more influenced when it's two people, they obviously know they need to reach a decision so they're more likely to compromise on their thoughts on what they're reviewing."*(Complainant 9, England)

*"If it had just gone to one or two people who just decided the outcome, I would definitely have less confidence, especially if it was something I felt was really serious and then it came back and it was just like a telling off or... I don't think I would have as much confidence. If it was going to a hearing, I think I'd be quite assured that they'd considered it in depth and detail, everybody's had different inputs from different angles, like legal angles, professional angles. I think I'd just have more confidence in that approach."*(Complainant 10, England)

- The nature of the **involvement of the complainant** in the new system was queried. Participants felt that it was essential that they still have a voice.

*"As long as the complaint is fully investigated and all people making complaints feel heard and not dismissed. I am fully onboard for the new system."* (Patients/service users who have considered complaining, London)

- Participants also wanted reassurance that **checks were made on any conditions** placed on registrants i.e. that they were monitored carefully to ensure adherence.
  - This was a particular issue for one complainant who discovered that her dentist, who was suspended, was still working.
- Some participants also wanted reassurance about the **right to appeal** in the new process (for both complainants and registrants).

*"It's like that decision's final, them two people have made that decision, whoever they are, and there's no appeal process. Whereas shouldn't there be a decision that, if they send that back to the person or whoever's made the complaint and they're not happy with that decision, then it can go to the next stage?"* (Complainant 4, England)

At the moment, effectively the Professional Standards Authority can appeal on behalf of the public. Further detail about the response to the proposed reduction in the number of hearings and the changes to oversight is provided in Sections 5 and 6 respectively.

## 5. The reduced use of panel hearings

### Section summary:

Participants raised a number of concerns about reducing the number of cases that go through to a panel hearing and only two clear benefits. However, the benefits identified were felt to be significant. They resonated with patients and the public as well as with complainants who had attended a hearing in the past. They had less resonance with complainants with recent or current experience of a fitness to practise process who had not attended a hearing.

#### Benefits

- Reduced stress for all involved.
- Reduced case length resulting in quicker imposition of sanctions and less risk of potential complainants being deterred.

#### Concerns

- Will registrants feel undue pressure to accept a decision?
- Lack of opportunity for a cross examination process.
- Will the process be robust and independent?
- What does this mean for transparency?
- Are hearings a deterrent to wrongdoing in themselves?

There is an expectation that there will be mechanisms built into the new process to address these concerns.

### 5.1 Perceived benefits of reducing the number of hearings

#### *No need to attend 'court'*

Whilst ensuring that complainants have a voice in the process was important, it was striking that most participants did not necessarily feel the need to have a panel hearing in order to have 'their day in court'. They tended to feel that there were other ways to ensure that patients or service users can have their say in the process. These are outlined in Section 7.2.

Furthermore, the fact that complainants would not need to give evidence at a panel hearing was seen as one of the key advantages of the emerging model.

*"For me, it seems very daunting. If that was me putting forward something like that, my vision is I'd be all by myself against the whole of these experts in front of me. What evidence would I need to bring, would someone hold my hand to this hearing?"* (Patients/service users who have considered complaining, London)

There was widespread concern that a panel hearing could be daunting for witnesses and could mean ultimately that complaints are not pursued, having a negative impact on the protection of the public/patient safety overall.

*"It seems to be you've already been through quite an emotional experience already before you make the actual complaint and then the whole ordeal"*

*just doesn't seem to be over. Which seems as though it could last quite a few months going through all that process, which then could distress you and make the whole experience 10 times worse than what you've already been through initially when you made the complaint."* (Patients/service users who have considered complaining, London)

Participants with no experience of the process posited this as a possible issue and this was also raised by those who had been through the process.

- Two interviewees, who had initially raised a complaint with a regulator, decided against taking it any further because the whole process, and the potential of a panel hearing had sounded so daunting when it had been described to them by a regulator (the HCPC/NMC).

*"I can remember them mentioning that it could go to a hearing but that there's no definite outcomes, people do make errors, and at the time I just thought... I don't even know if I was looking to get this one person in trouble. I just wanted them to realise what they'd put me through and the upset. So, in the end I left it, I didn't want to go any further, I just didn't have it in me at the time."* (Complainant 10, England)

- Another interviewee who had attended a panel hearing relating to a dentist who was subsequently suspended and then at a later date struck off, described how another patient had lodged a complaint previously but had decided not to go ahead because they had concerns about the process. She felt that the stress and expense associated with her negative experience could have been avoided if the original patient had been comfortable to proceed with the case.

*"I think the dentist I complained about, which I didn't know until afterwards, he had received a caution two years prior. I think the person that complained about it didn't want to take the case any further, which I can understand, not everybody wants to go in front of a panel...So I think he was just cautioned because there was no evidence against him. So, he probably slipped through the loop a little bit there on another serious case because the patient didn't want to do it."* (Complainant 3, England)

- However, a small number of complainants who were currently involved in, or had the most recent experience of a fitness to practise case, talked about the need to have their say in a public arena so that the registrant and others could hear and see first-hand the impact of the registrant's actions. One of the same participants went on to explain that in hindsight, when emotions were less raw, she recognised that the hearing was not necessary.

*"I was furious at the time, yeah, I did want it to go to a hearing and I'd have been happy with that outcome. So, as a mother, yeah, and a person, if it was any of my family then I would. But actually sitting back and looking, like I said, she's got an 11 year record clean...If I stood back and I wasn't*

*as emotionally involved, it probably was the right outcome.*" (Complainant 4, England)

### **Reduced case length benefiting those involved and more widely**

The increased use of consensual disposal was assumed to equate to the speedier disposal of cases. This was perceived to be a benefit in itself in that the complainant(s) and the registrant would have a quicker resolution and not have the stress and anxiety associated with a drawn-out process.

*"I think the benefit for them is that it doesn't hang over them like the Sword of Damocles for two years, like it hung over me. Because, whilst it's hanging over me waiting to go to a panel, it's hanging over that guy as well. Sitting there from their point of view, not everybody's a bad egg, some of them are good guys who have just got a sod of a bloody patient. Hopefully, the speed up of the process is to make it better for everybody concerned."* (Complainant 2, England)

It was also felt that reducing the average length of cases would ensure that the public is protected faster. During discussions, participants queried whether registrants were suspended whilst the case was being investigated. When they were informed that this was not always the case, they felt that it is important to ensure that sanctions are in place as soon as possible by expediting the process. For example, so that remedial action (for example, more training or supervision) can be taken to address any identified issues.

*"It just expedites the process for the people waiting at the end of it really. So, I don't think that's a bad thing, especially if they agree with the recommendations that have been made, it gives the medical professional a quicker opportunity to implement those recommendations or those restrictions anyway. Which means the public in general are getting protected sooner than they would if you had to wait for a hearing."* (Complainant 7, England)

## **5.2 Concerns related to reducing the number of hearings**

### ***Will the process be as robust and independent?***

Some participants queried the impact of moving to consensual disposal on the ability of the registrant to give full evidence and on the overall robustness of the process.

*"Because I'm guessing it's only at the hearing they get to bring their own witnesses? All of this investigation won't be done on anything... is the only chance that the person [the registrant] gets to present their side of the story at the hearing?"* (General public/patients, Cardiff)

*"I know some cases which go to a hearing can be expensive and drawn out and very time consuming. I'm sure everybody that's involved won't mind*



*putting up with how long it takes as long as they get to the bottom of it.”*  
(Carer, England)

*“It seems like it was quite an important part of the whole process so I don’t know whether cutting it out potentially would benefit all parties involved. It’s definitely easier and it would make the process quicker but I don’t know if it would mean that’s quite an important stage to miss out because, if maybe evidence was being given during the hearing, that might have been overlooked if the hearing was taken out completely.”* (Complainant 8, England)

Others were concerned about the independence of the process if a hearing is not conducted. This issue about a perceived lack of impartiality is further discussed in Section 6.3.

*“If it’s only going to be two to three people, it’s going to be quite important who they are and their credentials and where they stand in the whole scheme of things. They’re basically going to decide the fate of what happens to the case so I would want to know, personally.”* (Complainant 8, England)

*“I think that it doesn’t sound like a very involved process and may be decisions a panel is better versed to make. There is an impartiality and transparency that comes with a larger group of people.”* (Carer, Scotland)

### ***Importance of a cross-examination process***

Linked to concerns about the robustness of the process, participants did spontaneously identify a potential risk in terms of the reduced number of hearings which related to the lack of a thorough interrogation of the evidence in person. This was in relation to both the registrant and any witnesses.

*“Impact statements are important in judgement, or sentencing if you want to call it that, but I, again, think that the lack of ability to perhaps speak or be cross examined or questioned at a hearing, to dig out further facts, could bring out some critical things.”* (General public/patients, Cardiff)

They pointed out that sometimes only the ‘true’ character becomes apparent during a face to face meeting and that issues or true feelings (for example, a lack of remorse on the part of the registrant) could be masked on paper. Some participants referred to the risk of registrants being able to ‘beat’ the system (i.e. their wrongdoing not coming to light because there is no robust, face to face challenge of their version of events).

*“What makes me uncomfortable now is the fact that he’s [the registrant] probably not been interviewed or anything, he might have just got some communication over the phone or via email to say “this is what is going to happen, you’re going to be working with someone for the next however*

*many months” and, like you say, he’s probably thought “oh yeah, I can beat that”. (General public/patients, Leicester)*

*“People aren’t good at lying in person, like it’s easy over a piece of paper or the telephone, even a video link it would be easy but in person it’s much harder for them to lie. So, I think they should keep them up really, again, it’s the protection of the public.”(Complainant 7, England)*

Whilst this point was also raised by those who had had no experience of the process, one of the participants who had attended a hearing had an example of the importance of the registrant being cross-examined in a public hearing.

*“I think it would probably bring out the true character of the person. When I was in the witness waiting room, I heard an awful lot of shouting and I heard my name called, he was saying I was a “lying bitch”. I think it probably shows the panel more so what that person’s like as a person, the character of that person.”(Complainant 3, England)*

Equally, registrants may be able to convey their remorse and that they have taken remedial action more effectively in person:

*“Because, if that’s not there and you’re not speaking face to face, and you’re maybe not speaking over the phone and everything is going back and forth through the likes of emails or letters, I just find that letters and emails you can’t put everything down that you want to say, you can’t put down emotions, you can’t empathise through emails.” (Complainant 1, Northern Ireland)*

Some also felt that the witness should also be cross-examined thoroughly in person, as they were concerned, that in some cases, they may be tempted to exaggerate the impact or it may be a spurious or malicious complaint.

However, for some, the benefits of reducing the number of hearings outweighed this identified risk.

### ***What does this mean for transparency?***

Participants felt that the reduction of the number of hearings has implications for the transparency of the process. They queried what information would be made available to the individual complainant and the wider public more generally. They were concerned about decisions being made ‘behind closed doors’ and felt that, in the emerging fitness to practise model, action needs to be taken to ensure that information is accessible.

They, therefore, felt that it was key for information to be provided to the complainant relating to the registrants’ response to the complaint and the rationale for any decisions made. They also queried at what stage this would be made available – whether the complainant/witness would see the

information prior to discussions with the registrant relating to proposed sanctions.

Concerns were also raised about the reduced ability of regulators to identify wider patterns or system issues which may come to light if there is a public hearing.

*"If it goes to a hearing level and they're overseeing it, it may trigger things with "what's happening on a national level and we must never let this happen again and what are the procedures we need to change?" (General public/patients, Cardiff)*

### ***Will registrants feel undue pressure to accept a decision?***

There were some reservations about whether registrants would feel pressurised, under the new system, into accepting a sanction in order to avoid the stress and uncertainty involved in a panel hearing.

*"You might have people accepting strike offs and suspensions because this process, I'm likening this to a law court in my head and I've read this process is really damaging to mental health, and you might have people saying "do you know what? just strike me off because I can't take any more". And that's not necessarily fair either. Or they might come under pressure because of the costs to do it." (General public/patients, Cardiff)*

They felt that this could result in some decisions being unduly severe as there is a possibility that, if the registrant had elected to go to a hearing, it could have resulted in a more lenient sanction.

*"I just feel like maybe there could be some pros to it but there also could be some cons in terms of will cases get overlooked and just get thrown out and registrants or whatever won't get the discipline that they need? Or vice versa, maybe they'll get disciplined too hard because they're not going all the way." (Patients/service users who have considered complaining, London)*

Conversely, others felt that the new system could offer registrants an easy route out:

*"Would that be an easy option for him just to say, "I'll just have six months out of my suspension then I'm back to work", rather than make a fuss of it, challenge it and then go further to a hearing, when he could be struck off?" (Patients/service users who have considered complaining, London)*

### ***Are hearings a deterrent to wrongdoing in themselves?***

One participant mooted whether the threat of a hearing is important in itself as a deterrent to wrongdoing.

*"The hearings itself, as I say, they are very, very important, if they're not there I just feel then that there's not going to be that fear put into staff that there is this bigger organisation."*(Complainant 1, Northern Ireland)

### 5.3 Types of cases that should go to a hearing

Participants were asked if there were certain types of fitness to practise cases which, under the new model, they felt should always go to a hearing. They identified the following types of cases:

- Cases involving a **death of a patient** or a service user.
  - Most participants felt that cases involving the death of a patient or service user should result in a hearing. This was raised spontaneously at all the groups, on the bulletin board and in most of the depth interviews. Participants tended to assume that a case which resulted in the death of a patient would mean that there are more questions over the fitness to practise of a registrant than other types of cases. There was a strong feeling that the family of the patient would want answers and would feel more comfortable with the enhanced transparency of a panel hearing.

*"If it's led to loss of life, I can only assume that the relatives of the person they've lost would want everything... or seen to have everything done to get justice, and I just think going through this kind of process may not address that."*(Complainant 5, England)

*"If it was a case against a healthcare worker about loss of life or sexual assault then the thought of it not going to a panel would infuriate me. In the heat of the moment when I feel everything is against me I would feel like the hospital are trying to cover things if it didn't go to a proper panel. I would probably feel my matter wasn't taken seriously."*(Carer, England)

- However, not all participants agreed.
  - Some felt that, in these cases, the family of the deceased should be asked whether they want to go to a hearing or not.
  - Some felt that automatically going to a hearing could be traumatic for the family and others that they would also have an alternative in the form of legal routes for redress.
  - Others felt that, if the likely sanction was for the registrant to be erased, then there was less merit in having a hearing.

*"If a professional's going to get struck off and everyone's in agreement because he or she did something wrong, then I don't think putting it to a hearing is the right way to voice what's happened. There's different ways, through the media or through your own petition or something like that, but I don't think getting a panel together, getting a hearing which takes years, months, weeks, days and puts everyone through, I think, unnecessary stress when you're all on the same page anyway."*(General public/patients, Leicester)

- Cases involving **physical or sexual abuse** of patients.
  - One of the complainants interviewed had made a complaint to the GMC about an alleged sexual assault and felt strongly that the doctor in question should account for himself in public. The issue was also raised by some participants with no direct experience of this.

*"If something's had a detrimental effect, like different abuse; physical, sexual, anything like that should automatically go to a hearing, in my opinion."*(Complainant 4, England)

*"I think I would like other people to formally hear and discuss and decide about the outcome. So, if I didn't have to be in the same room as him, I would like the hearing to happen. I know it sounds weird, but I'd want him to have to answer for himself in front of people in a formal way, that's important to me."*(Complainant 12, England)

- Cases involving **multi-disciplinary teams and/or potential systemic failings**.
  - There was some concern that issues or patterns may be missed if individual regulators are dealing with these cases and there is no open process, such as a hearing, to explore the evidence.
- Cases involving a registrant who has had **previous involvement** in a fitness to practise case.
  - This suggests that the registrant has not learned from their previous experience and that any previous consensual disposal process has not been successful in resolving the fitness to practise issue, so another route should be tried.
- Cases that are **high profile or have affected a number of patients**.

*"Maybe ... if it's a case where it's affected quite a large number of people. Or perhaps it's actually not the first time that someone had made a complaint against that particular professional. I think it might be quite important if it's a repeat offence or if it has affected quite a large number of people as well."*(Complainant 8, England)

- However, some disagreed feeling instead that serious cases that have been through a criminal court should not necessarily also need to go through a fitness to practise hearing.

*"I thought, if we're looking at streamlining processes, if a doctor gets found guilty of manslaughter or something in a criminal court, if you're found guilty of manslaughter by default you're already guilty of all of this because you've just been found guilty in court. What is the point, if you want to streamline a process, in having a criminal trial and this [a hearing]?"* (General public/patients Cardiff)

- Cases that involve **erasure**.
  - There were mixed views on such cases. Some felt that the public would be protected if the registrant had been erased so there was no need for a hearing; especially as it would mean that any family members do not have to relive what happened.
  - Others were concerned that they should go through the full process because of the seriousness of the case.

*"If somebody's not going to be able to practise anyway then I suppose you could say why does it have to go to a hearing, because they're never going to be a danger or threat to the public again. So, I'm a bit torn really about that."*(Complainant 6, England)

*"In the situations where they majorly, majorly messed up and it's highly likely that they're going to get suspended or struck off, then I really don't see the use of having the whole panel situation. Especially if witnesses are giving evidence and, for it to be that serious, it might be quite traumatic for everyone involved and then you're spending money for an outcome that's inevitable anyway."*(Complainant 9, England)

- Cases that are '**in the balance**' or **particularly complicated**.

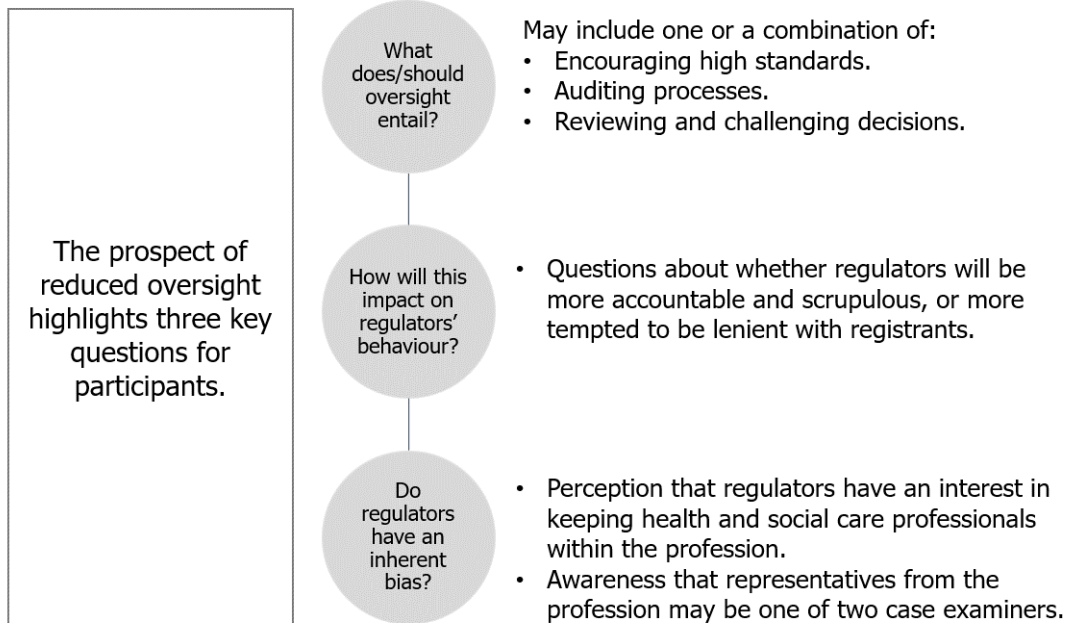
However, there was no consensus overall in terms of whether there should be fixed criteria about which cases go to a hearing (for example, all those that involve patient loss of life) as opposed to decisions being made on a case by case basis.

*"I don't think you can specify a particular type of case that "must" go to a hearing as each case, whether involving loss of life or not, should be judged on its own merits. A professional could take responsibility from the outset for instance and be fined and struck off."*(Carer, England)

*"I think a set system ... would work most of the time for all but there should be a system to rate those severe cases and make sure they don't get lost in the mix. I like the idea of a point system ..... these should fit into at least three levels of cases and the top of course being death or severe injury/loss of mobility should always go [to a hearing]."*(Carer, Scotland)

## 6. Potential changes in relation to oversight

### Section summary:



The potential changes in relation to the oversight of decisions in the emerging fitness to practise model were described to participants.

Overall, participants felt that some form of continued independent scrutiny of decisions was important and that there are inherent risks associated with moving from a system whereby a large number of decisions are reviewed, to one in which fewer decisions are scrutinised. Some viewed the Authority's current role as a safety net and could not understand the thinking behind the changes:

*"If you want to make it a more efficient process, by all means do that, have that panel, make some of the decisions and stop sending everything to hearing. Fine, but why does that come with removing the role of the PSA being able to challenge it? Why can't they have the best of both worlds, why can't they cut the process down, send less to hearings and still have the PSA challenge things?"* (General public/patients, Leicester)

*"I'd be wary that things might get missed in that sense because, in a situation where the PSA have been involved, if they maybe had something that they weren't... like "can you have a look at this, please, because we're not happy with xyz?", in a situation where they wouldn't have been involved at all, that might not have been flagged up or picked up. I don't know how that would work in the long run, like how many cases might get missed in that sense."* (Complainant 8, England)

*"It sounds a little bit like the equivalent of an ombudsman only doing a certain number or certain type of cases rather than the whole remit and I don't think that's a good idea. It feels a little bit like a money saving exercise and I think that patients would suffer as a result of that."* (Complainant 12, England)

However, participants varied in terms of how strongly they felt about this and there were minority voices who felt that oversight added another layer of bureaucracy:

*"The thing is, where do you finish it? Because even if you have a governing body that reviews these decisions, the governing body, it's like where does it end? Because the whole point of this surely is to simplify."* (Patients/service users who have considered complaining, London)

One participant indicated that they would be comfortable with no independent scrutiny of cases disposed of consensually, if he could be reassured about the past performance of the health regulators. He would want to know about their track record - i.e. how many errors/issues there have been with their decisions in the past. He suggested that the change didn't need to be across the board and some regulators could be treated differently (i.e. scrutinised more) if they've had issues in the past.

*"So, I suppose, if the GMC had 100 cases a year and the overarching body only found mistakes in one of them in a year, there was only 1% level of error, then you would say actually they're fairly trustworthy generally. So, if more things weren't reaching the panel, you would have a belief that those other things were equally being dealt with properly but, if you were overriding lots of their decisions on a regular basis, then the idea of more things going unseen obviously not such a great idea."* (Complainant 13, Scotland)

Some voiced concerns about a small number of people (sitting on Investigating Committees or as Case Examiners) making decisions on cases with no further oversight.

*"I know one is a healthcare professional, that's a link to the industry it relates to, and one's a lay member and stuff but, I hate to say it, people will see things very differently. Things with vulnerable young girls, perhaps women on that panel might have a very different opinion to how men might see it. So, you really do have to have that next step to sense check it."* (General public/patients, Leicester)

*"Surely you would have to look at the competency, the decision-making process, of those case examiners that are going to be making these decisions. Is there any ratification of that decision?"* (Patients/service users who have considered complaining, London)



As outlined in section 4.2, there was a broad consensus that the mooted changes were only acceptable in the context of a robust process leading up to consensual disposal.

## 6.1 What does/should an oversight role entail?

Participants had no awareness of the Authority or its role prior to the discussion sessions. Their views on the importance of oversight were in the context of having little knowledge of how the system currently works (other than being informed about the Authority's role in relation to the scrutiny of cases which go to a hearing).

They had several expectations of the oversight role in relation to fitness to practise:

- At a high level, they felt that the presence of an overarching regulator would be positive in terms of encouraging regulators to work to high standards and to be rigorous in the investigations and processes:

*"It's a bit like when you know the auditors are coming, if you've never had an auditor you wouldn't be as thorough with your record keeping kind of thing."* (General public/patients, Cardiff)

- They also felt that an organisation which sits above the regulators would have a unique perspective and be better able to identify systemic issues or patterns in complaints which would not be possible for individual regulators.

*"But as we say, the important thing is the PSA's review of cases. If it doesn't go to hearing stage, they cannot review and that is the problem. Because things may be slipping through at the middle stage and quite important national policy might not happen if things never come up for review."* (General public/patients, Cardiff)

- In terms of fitness to practise cases, they assumed that the Authority had (or should have) two functions:
  - To audit processes, possibly by conducting unannounced spot checks.

*"I think somebody, might not be them, but there needs to be something in place where maybe there has to be a random audit, maybe not as formal as it is now. A bit like when Ofsted are coming, or the CQC, you know it's going to be looming but you're not quite sure when. And they can do unannounced visits, so maybe something like they do a "right, we're going to take 10 random cases to look at", and it might be once a year or every couple of years or something like that."* (Complainant 6, England)

- To review and challenge specific cases.

Most participants felt that, under the future model, some of the cases that go to consensual disposal should be reviewed by an independent organisation. To

some extent this was to ensure that there was consistency between decisions made at panel hearings and decisions made by case examiners/investigating committees.

*"No, I'd feel like I'd been short-changed in a way if that was me. It's like "why can't you?" that's not fair if you can in a hearing but you can't if it's just an investigation. I'd be like "why, why didn't I know that, why didn't you tell me that?". So, I think it's like one rule for one and one rule for another."*(Complainant 11, England)

A small number of participants believed all cases should be reviewed but the majority were comfortable with only some of the cases being scrutinised, feeling that this is more proportionate. However, there was little consensus over which cases should be scrutinised. Some felt that those that result in a suspension or erasure should be reviewed; whilst others felt that those that have resulted in an erasure pose no risk to the public and so are not a priority.

Some queried the timing of the scrutiny, feeling that it would be better earlier in the process rather than a retrospective review.

*"The scrutiny needs to happen sooner in the process. It needs to happen at the investigating committee and case examiner's assessment stage."*  
(General public/patients, Cardiff)

## **6.2 Will the proposed changes change regulators' behaviour?**

Participants spontaneously raised questions about whether the changes to the process will impact on regulators' behaviour either positively or negatively.

There was some concern that, as more decisions would be behind closed doors, this could have an adverse impact on the robustness of the process. Some wondered if regulators would be tempted to be more lenient with registrants in order to ensure that more cases are agreed and, therefore, avoid an expensive and lengthy hearing. They also felt there may be issues relating to regulators 'marking their own homework'. These concerns reflect some of the evidence relating to the impact of switching the decision context from a public to private setting on the psychology of decision-makers outlined in the Authority's recent literature review<sup>8</sup>. The concerns are also linked to those outlined in section 6.3 below relating to whether those decision-makers may have a bias towards registrants.

*"I think that all decisions should be open to challenge. Especially when a hearing is not held, they need to be absolutely sure that all sides have been covered. And if not, the process should allow this to be challenged."*  
(Patient/service user who has considered complaining)

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<sup>8</sup> [https://www.professionalstandards.org.uk/docs/default-source/publications/from-public-hearings-to-consensual-disposal---insights-from-the-decision-making-literature.pdf?sfvrsn=6cc87420\\_0](https://www.professionalstandards.org.uk/docs/default-source/publications/from-public-hearings-to-consensual-disposal---insights-from-the-decision-making-literature.pdf?sfvrsn=6cc87420_0)

Participants who expressed such concerns felt that it was crucial, therefore, to ensure that there is independent scrutiny of the cases that go to consensual disposal.

A smaller number of participants wondered if the changes would have a more positive impact on regulators i.e. that they would become more accountable and scrupulous in their decision making as a result.

*"Are they [the regulators] then going to be stricter during that process, are they then going to say, "You know what, this suspension, we need to tighten up on this"?"* (General public/patients, Leicester)

*"If you have layers of reviewers, then the original doing the case might say "if we get this wrong it doesn't matter because somebody else will review it", i.e. that too many layers we'll almost think... rather than saying "let's try and make the right decision first time".* (Patients/service users who have considered complaining, London)

### **6.3 The perception that regulators may be biased**

Potential risks relating to a reduction in the number of hearings were raised in relation to whether regulators have an inherent bias (which could be unconscious) towards registrants. Participants were unsure if this was the case but raised it as a possibility. There was a question about the role of the regulator and whether they have a vested interest in being lenient towards registrants (for example to ensure that professionals remain within the profession).

Some felt that because the regulator was assumed to have representation from those in the profession being investigated, they may naturally side with them. For this reason, they felt that independent scrutiny was vitally important to both ensure that decisions weren't being made on a subjective basis and to maintain complainants' and the public's confidence in the process.

*"I know they've [the regulators] got a general guidelines but, if they think they can get away with lesser sanctions or something like that, rather than lose a good worker in their eyes, are they going to be likely to do that? Is the general public then going to be fobbed off with their technical jargon, you get confused and you just give up with it because it's beyond your capability anyway."* (Complainant 5, England)

*"Yes, but the word GDC to the public seems the club, the club for dentists, not the Monitoring Council, MC."* (Complainant 2, England)

*"The thing is with a doctor or a professional, what people have got to realise is that they've taken probably 10/20 years to train up and qualify for that position. Now, that is a big deal, big factor, and people are crying out for more doctors. So, there is going to be an element of protection there, they*

*want to minimise anything that can take a doctor away.” (Patients/service users who have considered complaining, London)*

Interestingly, the two participants who had attended a hearing were not of this opinion (both had been happy with the outcome of the panel). Similarly, a registrant who was interviewed because she was involved in a fitness to practise complaint as a patient, was of the view that the individual health regulators were not necessarily highly regarded by the profession itself and she would welcome independent scrutiny.

*“Well, you want to make sure that people are dealt with as they should be dealt with and, as I say, you don’t want people to slip through the net. Maybe it’s a trust thing, can we trust the GMC and the NMC to deal with their own cases without having to get an insider involved?” (Complainant 6, England)*

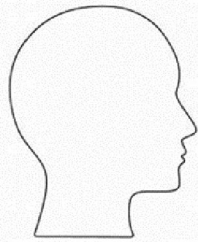
There were also questions raised about bias (conscious and unconscious) amongst case examiners:

*“I don’t know who these people would be and what their titles would be or what qualifications they would have, like what kind of bearing would they have, are they legal people or would they be acting on behalf of one of the parties, would they have some sort of bias?” (Complainant 8, England)*

*“Because people have attitudes and beliefs and sometimes it’s a bit unconscious, you don’t know that you’ve got them. I don’t think you can be without prejudice because we are prejudiced, we are human ... We’re not robots, we’re not programmed, so I think that you don’t know that you’ve got it and you might have missed something because of that, you might be blinkered because of that. So, I think that just two people, and especially from the same background, profession etc., it could have the wrong outcome.” (Complainant 11, England)*

## 7. Public/patient involvement in the process

### Section summary:



Participants raised several points in relation to their involvement in the fitness to practise process:

- The need to raise general awareness of complaints processes.
- The importance of the complainant being able to give their side of the story in a way that meets their needs – this could include face to face meetings and impact statements.
- The importance of keeping complainants abreast of developments in the case - and maintaining transparency.

### 7.1 Raising awareness of complaint channels

Given the typically low levels of awareness of regulation and complaints channels, there was a call for greater publicity about how complaints can be raised and the fitness to practise process more generally. Those participants who had raised a complaint felt that this was particularly important and highlighted some of the challenges that they had experienced in terms of knowing how to progress their case and who to approach in the first instance.

*"Procedure isn't just about who to complain to, it's about what happens as soon as you begin a process and, to be honest, I would say that, if you were to ask me, and I'm the sort of person who should know this stuff, if you were to ask me about GP a surgery or anything, actually I wouldn't know where to begin."* (General public/patients, Cardiff)

*"Without attending this session, I wouldn't have known any of this. It's nice to know that this is in place, but how would I have known, where would it have been advertised, how would it have been available to me, who would I have spoken to?"* (Patients/service users who have considered complaining, London)

Linked to this was the importance of encouraging complainants to come forward and get involved in a fitness to practise process. Participants described the numerous barriers to making a complaint, including the associated (presumed) bureaucracy, the length of time taken and the uncertainty of the result i.e. they may not achieve anything after expending time and effort. Others raised the concern that their complaint may be escalated and result in someone losing their livelihood.

*"I think that sometimes why people might not want to complain because you want them to be held accountable and you want to make sure that nothing bad happens to anybody, then you might worry that the extreme of it is somebody that just needs a talking to or monitoring might be sacked."* (General public/patients, Leicester)

*"If you've had free NHS treatment, you don't actually want to complain the same way as you might do if you were purchasing something in the shops. Because you're complaining about individuals then and they could actually be doing the best they can but it's other things that have got in the way."* (Patients/service users who have considered complaining, London)

## 7.2 Giving their side of the story

Whilst all participants felt that it was important for witnesses to be given the opportunity to give their accounts in full, there was no strong call for this necessarily to be done at a panel hearing. Rather, there were mixed views about how best this should be achieved. On balance, participants felt that it wasn't possible to have a 'one size fits all' approach and that the needs of the individual should be considered.

*"And some people just want to be heard, just want to be heard in an official capacity. It may be that actually they don't want to go through all of this really, they just want somebody to listen to them."* (General public/patients, Cardiff)

*"Written statements, record statements, video statements could be a simpler and quicker way of giving evidence without actually being there. Also, it would be less time consuming and cost effective without causing too much trauma and intimidation for the person."* (Carer, England)

Some felt that **face to face meetings** with witnesses would be beneficial. This was partly because they felt that the investigators would be able to make a more robust judgement about the quality and veracity of the evidence by meeting the individual in person. It was also in order that key points could be drawn out of the discussions which may not always become apparent from a written statement – it would allow investigators to put more 'flesh on the bones'. Participants raised the issue that there are some audiences, particularly vulnerable patients, who may not be able to articulate what happened to them clearly on paper, but would be able to do so during skilled questioning. Some participants raised accessibility issues and the fact that some witnesses would be unable to travel to meet in person or may be too intimidated to do so.

*"When somebody's stressed or has been traumatised or something like that, they might miss things. When somebody sits down face to face with a person they can ask the right questions, they can gauge the effect it's had on the person, how serious it is."* (General public/patients, Leicester)

*"There's bound to be a certain amount of patients out there that aren't great with filling in forms and documents and are going to fill out something and then two days later feel that they've missed something that should have been said. So how all of that is processed, I think, would be quite critical really, to try and make sure that the voice of the individual is fully heard."* (Complainant 13, Scotland)

Some also felt that a face to face meeting would help investigators ascertain if complainants were telling the truth.

*"I personally think in person is better because I think it gives a chance for whoever is assessing it at the time to kind of read for body language. They can catch you, rather than you just giving a statement, like if questions could be put forward or whatever. Because some people would obviously exaggerate the case."*(Complainant 7, England)

Some felt that **impact statements** would be a good way of conveying the emotional impacts of what has happened. They made the point that the full extent of the impact on a patient or service user may not be apparent otherwise. However, others felt that this type of evidence should be brought out already if the investigation phase was thorough and felt that an impact statement would not necessarily add any value.

*"I think you could do your own little statements, you can do these victim impact statements in criminal cases, and I think that would be a good idea. So that that person knows it's about being responsible for your actions, what that person's done, the impacts that it's had on those people...Because I think it would make it more real, I really do."*  
(Complainant 6, England)

One participant who had made a complaint but who had decided not to proceed with the case, suggested that witnesses should be given the opportunity to give a video statement. She felt that it was important that the case was not disassociated from the person involved.

*"I think it's important to get first-hand accounts from the people that actually had that thing happen to them. I think something gets lost when it's just been transcribed or written down on paper, maybe people skim over bits and it's like "okay, maybe that's not really important", but it's like it might be really important but you won't know from just reading some words."*(Complainant 8, England)

### **7.3 Continuing communication**

Whilst they understood that the complainant is not central to the process and becomes a witness rather than a key player, participants still felt that it is important to keep complainants abreast of developments in the case.

There was an expectation from some that there would be an online case management system which complainants would have access to. This tracking system would allow complainants to log on and see which stage their case was at and what actions had been taken and were outstanding. There was also an expectation that the communications process would take account of the individual witness' preferences i.e. whether they were happy to be emailed with updates or would prefer telephone calls.

Participants also tended to assume that there would be telephone calls at key junctures in the process (for example if the case met the threshold at triage and when the decision was made about whether to dispose of the case via consensual disposal or hold a hearing). They felt a telephone call would allow for explanation of the next steps or of how decisions were made. Some also felt that complainants should be given an opportunity to comment on the investigators' conclusions:

*"Even if it's a brief outline of the report, the patient or the relatives, the person making the complaint, can see their conclusions sort of thing. I think that's important because, again, the feeling you're included before it goes to the panel and then you're told about the outcome, it's like "hang on a minute". Because it gives the person who's complaining the option to go "no, no, that's not what I said" or "that's not right, that's a different thing to what I'm saying or what happened". (Complainant 5, England)*

*"So, could there be a patient representative type person that you, as the complainant, could go to and say, "can you explain this outcome" or "I don't like the outcome"? Somebody that you can go to and who will make sure that the case has been looked at for the patient." (Patients/service users who have considered complaining, London)*

There was a broad consensus that the complainant should have access to all information, including the registrant's response.

*"I think you obviously can't give too much control in a sense to people, there has to be procedures and protocols in place. I feel like maybe giving too much information sometimes can be more detrimental. But ... if the professional is getting sent that information, that information should also be sent to the person making the complaint. If it's fit enough to be sent to them, then it should be fit enough to send to the patient as well." (Complainant 1, Northern Ireland)*

They also felt that when the case was closed or at the point sanctions were agreed or imposed, this should be communicated in writing so that the witness has an official record.

Participants also called for clear information on the expected timescales throughout the process.

Some also suggested that, at the end of the process, there should be an opportunity for the complainant to give feedback on their experience so that regulators can learn from positive and negative views.

#### **7.4 Taking account of complainants' views**

Participants found it difficult to decide the extent to which complainants should have a say in terms of decisions relating to how cases are disposed of or the appropriate sanctions.



They empathised with patients or services users who may have experienced significant harm, distress or stress and feel strongly about the outcome of the case as a result. A minority felt that complainants should have a say in the disposal method and/or sanction, particularly if they were the main witness or if the case had had a significant impact on them.

*"The perfect change for me would be not only does like the medical professional have a say but, if the member of the public and the medical professional agree with the changes then fair enough, go ahead, that's fine. But, if the member of the public doesn't have a say whatsoever, I don't really think that's fair."* (Complainant 7, England)

*"Even if you did a telephone call or a telephone conference, before you make the decision call the person to tell them "okay, we've reviewed the evidence and we're going to do xyz and what's your opinion of it and how does it make you feel". Include some sort of statement from the complainant or involve them in some sort of way, I think that might compensate for it."* (Complainant 9, England)

On balance, however, most felt that complainants should not have a say on disposal methods or sanctions. They felt that, as long as the investigation process was rigorous and had thoroughly taken evidence from the complainant, that others (who are more objective) should then make the decisions. They tended to feel that those patients and service users who may have been adversely affected, will not be objective or in the right frame of mind to make the decision.

*"But then are you giving too much power to a patient or relative that is feeling aggrieved anyway. It's a fine line, isn't it?... Bearing in mind I've been somebody that's been particularly aggrieved, and I know at the time I'd have wanted everything possible to have happened. But at the cold light of day, is that really the right course of action?"* (Complainant 5, England)

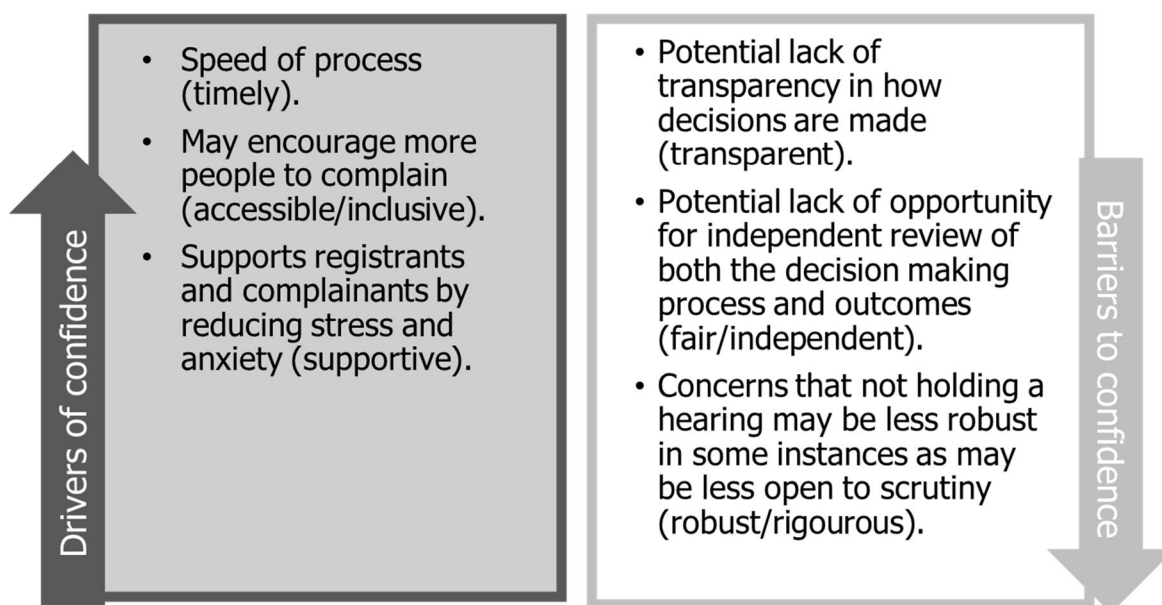
*"I think once, and if, the evidence has been gathered appropriately and in depth and they've had that discussion like a face to face and all the information's there, then it should go out of their hands, personally."* (General public/patients, Leicester)

Participants also commented that patients and service users had other routes of redress or channels in which to make their views known, for example taking legal action or voicing their dissatisfaction on social media.

*"Nowadays...people have the likes of social media, where social media becomes its own hearing in a sense. So I find that, if hearings weren't available and complaints and things like that weren't dealt with, a lot of people tend to go to news articles and magazines and things like that to report "this happened to me when I was in hospital".* (Complainant 1, Northern Ireland)

## 8. The impact of the changes on public confidence

### Section summary:



In terms of the impact of the proposed changes to the fitness to practise model on public confidence overall, it can be assumed to have limited impact because of the low existing levels of awareness of both the regulatory structures currently in place and of cases involving health and social care professionals' wrong-doing.

*"How would the patient know that there was a difference between the current system and the new system? If an undertaking is agreed under the current system, it's agreed and a patient who feels aggrieved is going to feel aggrieved. Under the new system, if an undertaking is agreed, how would they know that under the old system this would have gone to a panel?" (General public/patients, Cardiff)*

However, we are aware of the reference in the final judgement of the Bawa-Garba case<sup>9</sup> to public confidence relating to "fully informed and reasonable member of the public" and of "ordinary, intelligent citizens who appreciate the seriousness of the sanction, as well as other issues involved in the case".

The findings outlined in this report are based on the views of people who have considered the issues in greater depth, for more time, and with more information than members of the public who consider the issues in the course of their day-to-day lives. The feedback is, therefore, pertinent when considering the potential impact of the changes on an 'informed public'.

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<sup>9</sup><https://www.judiciary.uk/wp-content/uploads/2018/08/bawa-garba-v-gmc-final-judgment.pdf>

Whilst participants were not asked explicitly to generate principles that they would expect the process to adhere to, these did become apparent throughout the course of discussions. . It is perhaps helpful to review the changes through the lens of participants' expectations of the fitness to practise process overall:

- **Timely** - the new model has perceived benefits in that it is assumed that it will speed up the process and ensure that registrants and witnesses do not have to endure a long process and that patients and service users are protected more rapidly by the swifter imposition/agreement of sanctions.
- **Robust/rigorous** - there were mixed views about this – some felt that, by having fewer hearings, this may mean that the process may be less robust for some cases. They were concerned that cost-cutting may be a key driver of the change and efforts to reduce costs would take precedence over proper scrutiny. Some felt that the changes mean that regulators need to be scrupulous to ensure that the process up to the point of disposal is robust in order to minimise this risk.

*"If you start taking people out the picture, I feel as if the whole system's just going to become very unsafe. It's like when you have an extension, you get a qualified person to check it. Now that qualified person is also checked by a more qualified person for that reason, and that's where I feel like the PSA is there as a double check."*(General public/patients, Leicester)

*"So, if any slip ups happen, then they should be thoroughly looked into, and the fact that with the change they wouldn't be as thoroughly looked at I think, personally for me, would give me way less confidence in the medical industry."*(Complainant 7, England)

*"If there is no authority, like what we've just discussed, having the authority scrutinising all the really severe cases, if that was completely abolished, they only get involved in the ones that do go to trial, I think that would lose public confidence."*(Complainant 5, England)

- **Transparent** - whilst there were some concerns about the fact that more decisions will be made behind closed doors, this did not necessarily translate into a call for the use of hearings at the current rate. Instead, participants felt that efforts should be made to ensure transparency within the alternative process, including allowing access to the registrant's response to allegations and information on how/why case examiners reached their decision.

*"I think, if you asked me to choose, if I have to go with the new one [fitness to practise process], with a question mark [over] transparency and consistency with the standards....you'd have [to have] somebody that you could trust that would tell you why it [the decision] happened, what happened, so that you feel empowered and you've not been shoved out and somebody's made this decision behind closed doors."*(Complainant 11, England)

- **Fair/independent** – ensuring that the process is fair for both registrants and complainants is key. Participants had little knowledge about whether to have confidence in the independence and objectivity of the ten health and social care regulators or whether they were likely to favour registrants over patients. There were some underlying concerns about the possibility of the latter which, coupled with concerns about reduced transparency, strengthened calls for independent scrutiny (or ‘checks and balances’ in the system).

*"I think there still should be oversight. It should not be seen as a closed cartel, a gentleman's club for dentists and by the way, "we'll hush this up and sweep it under the carpet." (Complainant 2, England)*

*"From the claimants' point of view I would see this potential change as yet another hurdle to jump over, stacking the odds in the defendant's cases as they are being reviewed by their peers." (Patient/service user who has considered complaining, Northern Ireland)*

- **Accessible/inclusive** - some participants indicated that they felt the new process may encourage patients or service users to raise complaints because they were less likely to have to face a daunting hearing. This could enhance confidence in the process.
- **Supportive** – reducing the number of hearings was seen as a supportive move for both registrants and complainants as it was believed it would reduce some of the stress associated with the fitness to practise process.

*"I believe the public would be pleased that the concerns are being taken seriously and dealt with in a more "sensitive" way while the professional is being treated fairly." (Patient/service user who has considered complaining, England)*

Participants stressed the need for **ongoing evaluation of any changes** to the process and a willingness to amend it if it is not felt to be working:

*"To improve confidence of complainants and members of the public it will be necessary to have some test cases - to ensure due process is carried out / if proposed changes are not as efficient as hoped it would be best to return to old system or change the committee/assessment/examiner - to be nearer the model of panel but be more cost effective." (Patient/service user who has considered complaining, Northern Ireland)*

Participants also highlighted the risks of change and the potential detrimental impact on public confidence if the process is not sufficiently robust and a case slips through the net.

*"You get that in a situation where you go 10 years down the line, "oh my God, this doctor, they only gave him a suspension and he took it and then for the next 10 years took out all these patients" because he should have*

*gone to a hearing but they changed the system. So, we can't tell what will happen and what cases come along.*"(General public/patients, Cardiff)

## 9. Conclusions

There was a general feeling that the proposed changes are likely to have little impact on public confidence as a whole given the low levels of awareness of regulation and fitness to practise cases, coupled with the relatively high levels of confidence in health and social care professions. However, it was acknowledged that this could change if a concerning case involving a health or social care professional, who had caused significant harm to patients or service users, came to light that had been dealt with inappropriately by consensual disposal.

Participants generally felt that the review of the fitness to practise process was positive in order to ensure that it is still fit for purpose in changing times. The proposed reduction of the number of hearings conducted was broadly welcomed by participants. It was felt to be a sensible and pragmatic response to tackling the disadvantages associated with the current system, in particular the time taken and stress experienced by all parties. They felt that the change could have a positive impact on protecting the public too, as the process will be less daunting for complainants (and so cases may be brought which wouldn't otherwise have been). Furthermore, there was an assumption that cases will be processed more quickly, meaning that the public will be protected sooner than would be the case if a hearing was conducted.

However, participants immediately questioned the motivation for the changes. They wanted to be sure that the drive for the reduction in the number of hearings was to address identified issues, rather than to cut costs, reduce a case backlog, or massage fitness to practise case numbers.

They also wanted reassurance that, if the witnesses and the registrant are no longer cross-examined in public at a hearing, the complainant will still have a voice and the evidence will be properly scrutinised and challenged. They called for witnesses to be able to give their side of the story in a way that is as user-friendly as possible and which still is able to convey nuance and emotion.

There was also some unease about a possible lack of transparency within the consensual disposal process with some underlying concerns about the impact of decision-making behind closed doors and a possible inherent bias towards registrants. Participants wanted these concerns to be addressed by information sharing with the individual complainant and more widely, in addition to proper independent scrutiny of the process.

Overall, the majority of participants felt that independent oversight should be retained and there was a clear need for 'checks and balances' within the system. They felt that there were inherent risks with a simultaneous move to a reduction in the number of hearings and a corresponding reduction in scrutiny. Whilst participants were unsure if the individual regulators would actually favour registrants, there was certainly a fairly widespread assumption that this

was a possibility. They felt that there was a need to retain greater scrutiny of consensual disposal cases by an independent organisation to ensure that the process is impartial (and is seen to be).

All participants concurred that, under the new system, they would expect that some fitness to practise cases will still go to a hearing. However, there was little consensus as to which cases this would be. Some felt that the criteria should be the extent of the impact either in terms of how severely an individual complainant was affected or the numbers of people affected. Many participants (but by no means all) felt that cases involving a patient death or a serious sexual assault should go to a hearing. They felt that the bereaved family or the complainant would want to see the registrant answer for their actions in public. Others felt that a hearing, in these sorts of cases, would be an additional burden on those patients or families affected and could create additional trauma. Some felt that cases which impact a large number of patients or service users; or those which involved health and care professionals from different disciplines, should go to a hearing to ensure that wider learnings are not lost.

Similarly, there were mixed views on whether participants were comfortable with cases which resulted in the erasure of a professional going to consensual disposal.

There was also a strong call for any changes to the process to be carefully managed, monitored and, ideally, piloted. The changes were only felt to be acceptable if there is confidence in the process leading up to disposal. Participants, therefore, assume that there will be spot checks or audits of the process. One participant also felt that the individual regulators should only be able to move to greater use of consensual disposal if they have proved their competence in dealing with cases already.

# 10. Appendices

## 10.1 Appendix 1 – Sample breakdown

### Group discussions

No.	Overview of group	Type of health and social care experience	Age	Presence of LTC or disability	Ethnicity	Gender	SEG	Location
<b>Face to face discussions</b>								
1	General public	None with extensive experience	18-45	No	1 x BME	3 male 2 female	2 x ABC1 3 x C2DE	Leicester
2	General public	None with extensive experience	46-75	No	1 x BME	4 male 3 female	4 x ABC1 3 x C2DE	Cardiff
3	Have considered raising a complaint about a health or care professional	All extensive experience. Mix of different types of health & social care experience	24-65	Yes	2 x BME	3 male 4 female	4 x ABC1 3 x C2DE	London
<b>Online discussion board</b>								
4	Have considered raising a complaint about a health or care professional	Mixed level of experience. Mix of different types of health & social care experience	30-64	Mix	2 x BME	3 male 3 female	5 x ABC1 1 x C2DE	2 x NI 2 x Scotland 2 x England
5	Carers	Mixed level of experience. Mix of different types of health & social care experience	19-68	Mix		3 male 3 female	3 x ABC1 3 x C2DE	2 x Scotland 4 x England





## Depth interviews with complainants

Interview No.	Regulator involved	Involvement in fitness to practise	Gender	Location
1	NMC	Submitted complaint but not investigated	Female	NI
2	GDC	Complaint was investigated and went to hearing	Male	England
3	GDC	Complaint was investigated and went to hearing	Female	England
4	GMC	Complaint was investigated but did not go to hearing – undertakings agreed	Female	England
5	GDC	Submitted complaint but not investigated	Female	England
6	GMC	Complaint submitted by GP Practice, awaiting a hearing	Female	England
7	GDC	Submitted complaint but not investigated	Male	England
8	HCPC	Submitted verbal complaint but did not follow through	Female	England
9	NMC	Complaint submitted, awaiting outcome	Female	England
10	NMC	Submitted complaint but not investigated	Female	England
11	GDC	Submitted complaint but not investigated	Female	England
12	GMC	Complaint being investigated	Female	England
13	GMC	Submitted complaint but not investigated	Male	Scotland

## 10.2 Appendix 2 – Research instruments

Links to the research instruments can be found by clicking on the paper clip icons below:

Discussion guide for group discussions 


Discussion guide for depth interviews 

Questions for bulletin board 

Handout A – List of Professions and Regulators 

Handout B – Explanation of fitness to practise and sanctions 

Handout C – The current fitness to practise process 

Handout D – How the fitness to practise process may change 

SCENARIO 1 

SCENARIO 2 