Response to the GMC consultation on the Anaesthesia Associates and Physician Associates Order Rules

May 2024

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

1.2 We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

1.3 We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards. To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care.

1.4 Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.5 We welcome the opportunity to respond to the General Medical Council's (GMC) consultation on the draft Rules implementing the Anaesthesia Associates and Physician Associates Order (AAPAO). This response focuses on the Rules themselves (and related aspects of the AAPAO), and we will be providing feedback on the draft guidance for fitness to practise decision-makers separately. In the time allowed, and given the length and complexity of the consultation, we have

highlighted only key points in this response. The absence of commentary on any aspects of the consultation should not, under the circumstances, be taken as an endorsement.

2. Key concerns

2.1 We find that our areas of concern fall into two broad categories: concerns about the implementation of the Anaesthesia Associates and Physician Associates Order (AAPAO), and concerns about the Order itself. The former constitutes the bulk of our response to this consultation. Any comments made here about the Order will also be shared with the Department for Health and Social Care, so they may be considered as part of work on the blueprint for the next phases of reform.

Fitness to practise (FtP)

Number of case examiners

2.2 We have serious concerns about the GMC's decision to use only single case examiners, and not to give themselves the option of using them in pairs. In our view, regulators should give themselves the flexibility to use one or two, as each case requires, on the basis of criteria set out in guidance.

2.3 This is the position we set out in our recent consultation on guidance on the use of accepted outcomes, and responses point towards strong support for the proposition that some cases may benefit from more than one decision-maker. Over 80% of respondents to our public consultation agreed that more than one case examiner may be required for some cases, with just over 10% disagreeing. A large number of respondents raised concerns about cases being decided by a single case examiner, with many respondents believing that using two case examiners was more likely to result in a fair and robust outcome.[1] It is also in line with the policy intent set out in the most recent Government statement on the subject, which suggests that multiple case examiners should continue to be a feature: '*the government remains of the view that the GMC should continue to have a discretion as to how many case examiners it appoints to make a determination on a case. This is on the basis that, in providing that discretion, the regulator is best placed to assess where multiple case examiners may or may not be required, ensuring a proportionate and timely outcome where cases are referred to case examiners*.'[2] And while

[1] https://www.professionalstandards.org.uk/what-we-do/improving-regulation/consultation/consultation-on-psa-good-practice-guidance-documents
[2] https://www.gov.uk/government/consultations/regulating-anaesthesia-associates-and-physician-associates/outcome/consultation-response-to-regulating-anaesthesia-associates-and-physician-associates

we recognise that the AAPAO gives the GMC the discretion to use single case examiners, there is nothing in this Order suggesting or requiring this as either the default, or the only option.

2.4 We were not convinced by the arguments for the proposed approach set out in the GMC's consultation document, noting that currently case examiners can only make decisions in pairs. We disagree that the Rules offer flexibility (p40) – they seem to us to do the opposite, by stipulating that decisions should only ever be made by one case examiner, and by further ruling out the option even of choosing between a lay or professional decision-maker.

2.5 Rather than relying on notions of modernisation and streamlining, the GMC might have put forward some evidence as to why two case examiners, including the dual lay and professional perspectives, were not considered necessary, what precise benefits would be gleaned from the proposed approach, and how it might yield just fitness to practise decisions that protect the public, including maintaining public confidence.

2.6 The GMC's position suggests that there is no difference between the decision-making qualities of a single case examiner compared to pairs of case examiners. As is made clear in our draft guidance, there are legitimate concerns that the use of a single decision-maker may increase the risk and/or perception of bias. Conversely, there is evidence that decision-makers working together may bring a wider perspective which can help to counteract bias and may lead to more balanced decisions. We were surprised not to see any discussion of this question in the GMC's Equality Impact Assessment on the Rules.

2.7 It is also self-evident that having two (or more) decision-makers creates the opportunity for challenge and questioning by one of any poor judgement by the other. Yet it seems highly unlikely that this kind of flaw in decision-making would be capable of being challenged under the grounds for revision in the AAPAO of 'error of fact or law'. It is therefore all the more important that the original decision effectively protects the public.

2.8 We strongly recommend that the GMC reconsider its position on the number of decision-makers so as to retain the flexibility to use multiple case examiners where this may be required, as envisaged by the AAPAO, and to develop a policy to ensure that each option is used to best effect for fairness and public protection.

Case examiner referrals to a Tribunal

2.9 The GMC's interpretation of the case examiner powers to refer a case to a Tribunal seems inconsistent with what is in the AAPAO – the scheme it has set out for case examiner decisions appears to ignore that there are two points in the process at which the case examiner must consider whether to refer to a Tribunal, and focuses on the second (as an alternative to imposing a final measure where they have found impairment), while largely ignoring the first (as an alternative to making a

determination on impairment). In the interests of public protection, it is important that case examiners are granted a clear and unambiguous discretion to refer a case to a Tribunal where they feel this is needed. This could relate, for example, to the need to assess insight, which the GMC's own draft *Principles to inform impairment guidance* acknowledge Tribunals may be better placed to do.[3] This discretion is all the more important in the light of the GMC's decision to use single case examiners.

2.10 Our accepted outcome guidance is intended to help regulators support their case examiners to make sound decisions about whether they, or a Tribunal, are best placed to resolve a case – it will not be binding, but we trust that the GMC will consider the contents carefully when thinking about the basis on which they want case examiners to make these decisions, in line with the legislation.

Early stages of the FtP process

2.11 The Rules provide little information about the stages of the fitness to practise process before the decision is made as to whether a case should be referred to case examiner, a decision point that seems to be equivalent to the real prospect test. We had hoped to see this here, so we could have some clarity over these stages, which already under the current regimes lack transparency. We trust that the GMC will be consulting publicly on the detail of this, and in particular, how it will work for those bringing complaints as well as those against whom a complaint has been brought.

2.12 It also appears that there won't be any mechanism for members of the public to request a review of a decision to close a case in these early stages. These types of decision can be reviewed currently for doctors under the GMC's Rule 12, and this will continue to be the case until changes are made to the Medical Act 1983. It would be a backward step for there to be no equivalent for complaints about AAs and PAs, and for other professions under the new model going forward.

An imbalance between registrant appeal rights and public protection mechanisms

2.13 The GMC's Revision and Appeal Rules highlight the imbalance in the model between the registrant's appeal rights in relation to case examiner decisions, and the ability to challenge these decisions on public protection grounds.

2.14 Having been assured that the regulator revision power would be a suitable alternative to s.29 powers (our preferred option), we were concerned to see this power in the legislation ultimately whittled down to a narrow test of an 'error of fact or law', unfit for the purposes of public protection. This inadequacy has been further compounded by the granting in the Order of an internal appeal right for registrants, which the Appeals Rules will allow if a decision is considered 'unjust'. This is in addition

[3] At p 11 and 13.

to the registrant's right to request a revision – a tacit acknowledgement of the limitations of the 'error of fact or law' test. On the side of public protection, there will be no equivalent appeal rights or mechanism, whether by an affected member of the public, or the PSA.

2.15 It is worth remembering that the PSA's s.29 powers to challenge fitness to practise final decisions were put in place precisely to redress this kind of imbalance, described as a 'loophole' by Ministers at the time. [4] Looking in the round, we can only conclude that the public protection mechanisms relating to case examiner decisions remain inadequate. We note that this is an issue with the Order itself, rather than a consequence of the GMC's draft Rules, and we will be raising this concern with DHSC in an effort to improve the blueprint legislation before it is rolled out to large numbers of registrants.

Loopholes relating to our s.29 powers

2.16 The PSA will have s.29 jurisdiction over decisions, whether made by case examiners or Tribunals, to review conditions and suspensions. It will not, however, have equivalent jurisdiction over internal panel appeal decisions under article 16(5) of the AAPAO to quash such a decision, or substitute it. It is also unclear whether the PSA would have the s.29 power to challenge Article 13(1) decisions remitted to a decision-maker other than a Tribunal under 16(5)(d), where the PSA had the ability to appeal the original decision. These gaps will undermine our s.29 jurisdiction and create a public protection loophole, and we will be raising this concern with DHSC.

Education and Training Rules

Acting on concerns about a course or curriculum

2.17 It is unclear if the Rules enable the GMC to take action in response to any significant concerns that are raised with it regarding a course or curriculum, which might not be viewed as part of the monitoring and quality assurance processes. There is no specific mention of concerns in these Rules and so we are seeking clarification on whether or how the GMC would have the power to investigate concerns about a course or curriculum.

[4] https://publications.parliament.uk/pa/cm200102/cmstand/a/st011213/am/11213s03.htm

Flexibility over course approval

2.18 The Rules state that the GMC must (rather than has the power to) approve a curriculum or course if it meets the Standards set out in the accompanying documents. This puts a significant burden on the Standards to address all relevant risks. The GMC would need to consider how it might address significant risks that could arise but fall outside the scope of the Standards, and whether it would be more appropriate in terms of patient safety to maintain a degree of flexibility over the final decision on approval.

3. Further general comments

3.1 The PSA will be considering how to implement its right to request a revision of a case examiner decision, and approaching the GMC to explore how this will work in practice, including questions about notifications, provision of information, and so on. We note the three-month limit on requests for revision, and will take this into account when we consider our options.

3.2 The GMC is granted discretion in a number of areas over what information it publishes. We would welcome further consultation and engagement with the GMC as it develops its publication policies, and have highlighted a number of decisions below that we would like to see published.

4. Detailed feedback

Reference in document	Suggested area for comment
General Medical Council (Registration) (Anaesthesia Associates and Physician Associates) Rules 2024	
Voluntary removal	
9., 10. & 11.	We welcome the proposal that case examiners should make decisions on voluntary removal (VR) after referral of the case to the case examiners, and similarly following referral to the Associate Tribunal. Decisions on applications for voluntary removal after a concern has been received about the registrant, but before the case has been referred on to case examiners would sit with the registrar. We would want to know more about the factors that would guide a registrar's decision at this early stage, where a decision may be made with incomplete information. We draw attention to the need for voluntary removal decisions to be based on all three limbs of the GMC's over-arching duty, to include public confidence and the upholding of professional standards. In our response to the AAPAO consultation, we explained that these decisions should only be made where the investigation is sufficiently advanced to ensure that no significant aspects of the case have been overlooked, and there is enough information about the concerns to inform a decision in the event of an application for restoration. Noting that the GMC has the power in these instances to request further info under Rule 8(1)(b), and to refuse to make a decision if information is not provided (9(2)), we would expect it to use these powers to make sure that decisions to allow VR are sufficient for public protection. These decisions should also be published (subject to the usual caveats about respecting confidentiality where concerns relate to health conditions or there are other overriding public interest reasons) – we could not see anything in the Rules requiring this, noting that this is a power rather than a duty under Art. 3(1)(c) of Schedule 3 of the AAPAO.
11. & Rule 24. of the FtP Rules	We note the facility for case examiners to withdraw their referral of a case to a Tribunal under 10(6) of the Order and Rule 24 of the Fitness to Practise Rules. We would expect Rule 11 (Registration) to cover this eventuality, namely how this would affect the exercise of the Registrar's duty/ability to refer an application for Voluntary

	Removal to the Tribunal once the case has been referred by case examiners. There does not appear to be a corresponding ability for the VR referral to be withdrawn.
Removal of an entry to the register for non-FtP reasons	
14.	We trust that in the case of a registrant being removed for fraudulent entry, the GMC would seek to notify the employer, and any other affected parties the GMC is aware of, particularly patients and families who might have been affected by the actions of the registrant. Although a rare and extreme example, the case of Alemi is a reminder of the public protection implications of fraudulent entry to the register. We would also expect these decisions to be published – noting the discretion the GMC has under the AAPAO about publication of removals under Art 9(2) of the Order.
15. & 16.	We would expect the GMC to notify the employer in the event of removal for both failure to pay the fees, and failure to maintain adequate insurance and indemnity.
16.	It was not clear to us how the GMC would deal with a case of a registrant being found to have inadequate insurance or indemnity arrangements alongside other fitness to practise concerns, or as a fitness to practise concern in and of itself. There is distinction between not having appropriate cover (failure to satisfy requirements for registration, leading to administrative removal) and (knowingly) practising without appropriate cover (a form of dishonesty/recklessness, leading to FtP action). We note that 16(1) gives the regulator *discretion* to remove a registrant here – there should be some acknowledgement that a decision may need to be made about whether to deal with the case through administrative removal or FtP. This decision would need to take into account the differing requirements for re-entry that apply to each of these two routes.
Re-entry after removal	
19.	It would have been helpful to have a better understanding of how decisions about re-entry following administrative removal for failure to have inadequate insurance or indemnity arrangements would be made. As noted above, the robustness of requirements for re-entry in such circumstances should be a factor in any decision about whether to deal with a case through FtP or administrative removal.
General Medical Council (Fitness to Practise) (Anaesthesia Associates and Physician Associates) Rules 2024	
Initial assessment of a concern	

3.	The Rules add little to what is in the Order in Art 10(1) in terms of the early stages of the FtP process – what decisions will be made when, and on what basis, ahead of a decision about whether to refer a case on to the case examiner. We had understood that in the absence of detail in the legislation, this would sit in the rules, but this does not appear to be case. It is essential that there is transparency and clarity about these early stages, which represent the entry point to the process for both complainants and registrants. In our 2017 publication, *Right-touch reform*[5] we expressed concerns about how little of these processes was codified in legislation and/or rules, and how this could encourage unhelpful divergence between the regulators, in terms of both process and outcomes, in addition to concerns about transparency. We trust that the GMC will be consulting extensively on the approach to these early stages, and that there will be full transparency about what they involve.
3.	The decision about whether to refer a case to a case examiner, the 'test for onward referral', appears to be equivalent to the real prospect test currently used by case examiners and investigating committees. We would welcome more information about this test and how it would be applied, including the use of new guidance about what constitutes impairment. We find the terminology itself ('test for onward referral') unhelpful – unlike the 'realistic prospect test' or 'case to answer test', it says nothing about the threshold to be applied. This creates a risk of circular/unhelpful language elsewhere (e.g. cases will be referred onward when the test for onward referral is met).
4(6)	While it is helpful to have set out the Rules what the GMC may do to communicate with the person who raised the concern, we found that what was described fell short of what we would expect here. There should be a requirement in the Rules for the GMC to tell a complainant (where there is one) that it has closed a case and to give reasons. We note the asymmetry between 4(5) (*must* tell the registrant within 5 business days) and 4(6) (*may* notify the complainant). It would be helpful to know more about what the GMC is doing to consult with patients, families, and others who have experience of bringing a complaint to the GMC, to develop their approach to the early stages, and communication with complainants. The accepted outcomes process has the potential to feel less transparent to

[5] https://www.professionalstandards.org.uk/publications/detail/right-touch-reform-a-new-framework-for-assurance-of-professions

	a complainant than one involving a public hearing[6] – particularly given the lack of transparency about the early stages (see above), so we would urge the GMC reconsider how it will engage with complainants under the new regime.
5(9)	There is nothing to explain the circumstances in which it might be proper for the Regulator to withdraw a case that has been referred to the case examiners. We would welcome greater clarity on this point, which we expand on below.
Interim Measures	
7(2)	The drafting of this rule would seem to have the unintended consequence that proceedings would be halted if the registrant refused to confirm their name and reference number while present. This drafting is replicated at other points in the FtP Rules where the procedure to be followed at a Tribunal hearing is described – 16(2)(a), 41(1)(a), 42(1)(a), 44(2)(a), 66(2)(a).
7(8), 13(3), 16(9)	It was not clear to us why the GMC should have discretion as to whether to notify the associate's employer where known, after an interim measure has been imposed or reviewed. This would seem to be of the utmost priority, given that interim measures are reserved for cases where there appears to be a serious risk to the public, and will involve a restriction on the registrant's practice. We note that equivalent rules for substantive decisions, for example where there is no impairment but a warning has been imposed, require the GMC to issue these notifications. In addition, the wording appears to mean that if they do not do so within 10 days, they cannot do it at all.
8(5)	We would welcome more information about how the regulator would decide whether to refer the case to case examiners or an Interim Measures Tribunal. Elements of our guidance on use of accepted outcomes may be helpful to guide such decisions, and we will consider this as we review the guidance in response to the consultation responses we have received.

[6] https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf?sfvrsn=36897620_5

9(1)	We find the drafting of this rule unclear, in that it does not appear to acknowledge that the case examiner's decision will involve two stages – deciding whether an interim measure remains necessary, and if so, whether the measure should be extended, varied, or revoked. It may not be possible to make a decision on the former, without consideration of the latter. The drafting of this rule could perhaps mirror the drafting at 16(2)(b)(ii) which describes the equivalent stage of the Tribunal's decision-making.
General	Incorporating case examiners into the process for review of interim measures would seem to add time and complexity to the process, for those cases that are referred first to the case examiner, and then on to a tribunal. These are time-sensitive, urgent decisions from a public protection perspective. The requirement in the AAPAO for an interim measure to be reviewed prior to its expiry presumably also means that the GMC would have to build in a buffer for any interim measure review decision, in case it takes the longest possible path through the process, or rely on applications to the Courts for extensions where they have failed to make a decision internally prior to expiry. We note that any delays where a review has been directed on the basis of a change in risk could put the public at continued risk. Finally, we would like to know more about what legal advice will be available to case examiners making decisions about interim order reviews, and whether this might be a factor in referring a case on to a Tribunal to determine. This is a point we pick up again in our feedback on substantive case examiner decisions.
Consideration by a case examiner	
General	As explained in our introductory comments, the proposal to use single case examiners for every decision is of significant concern. While we recognise that the AAPAO gives the GMC the discretion to use single case examiners, there is nothing in this Order suggesting or requiring this as the default, or only option. We strongly recommend that the GMC reconsider its position on the number of decision-makers so as to allow pairs of case examiners, and to develop a policy to ensure that each option is used to best effect for fairness and public protection. We were concerned to read in the consultation document (p37) that the intention is to introduce an accepted outcomes process that is 'focused on reaching agreement with associates'. We agree with the aim of creating a

	less adversarial process where possible. But the GMC's overarching duty is to protect the public and all three limbs of that duty must remain the primary aim of any fitness to practise process. Giving – or seeming to give – primacy to the aim of reaching an agreement can give the impression of a negotiation or bargaining process, in which public protection may be compromised.
17(1)(c)	As set out in our opening commentary above, Rule 17(1) purports to set out what the case examiner must do where a case is referred to them, however it seems inconsistent with Article 10 of the AAPAO. The effect of Article 10(2) is that case examiners may decide to refer a case to a Panel without having considered/as an alternative to considering the issue of impairment. While the power to refer is included in Rule 22, the current drafting does not make any provision for how that power fits with the scheme for consideration by case examiners set out in Rule 17(1). We would have expected to see at the end of 17(1)(c) inclusion of drafting along the lines of: *'…or whether the case should be referred to an Associates Tribunal pursuant to Rule 22'.* Even if the Rules are not amended in this way, the power set out in Rule 22 will nonetheless need to be exercised by case examiners under guidance, and we would recommend that it is based on the factors that we will be publishing in the summer in our guidance on the use of accepted outcomes.
19(1)	It is unclear whether the discretion granted to case examiners here by the 'may notify the associate of the terms on which the associate may agree to have the case disposed of' applies to the notification or to the method of disposal. It reads as though it is the former, but would logically appear to be latter, as in practice they will have to notify the registrant of a proposal to agree to a final measure. We suggest this paragraph is redrafted to remove this ambiguity, and to clarify that the alternative to offering a consensual disposal would be to refer the case to a Tribunal, as per Art 10(3)(b)(ii). This decision by case examiners would need to be taken under guidance, and we would recommend that it is based on the factors that we will be publishing in our guidance on the use of accepted outcomes.
22	Rule 22 says case examiners may refer to a Tribunal under article 10(4) but does not mention that they may alternatively refer under article 10(3)(b)(ii), whereas Rule 23 refers to both.
23	Rule 23 does not say anything about who, apart from the registrant, the GMC may or must notify of the decision to refer to Tribunal, while Rule 24(3) presumes that other parties will sometimes be notified. We suggest Rule 23 may need to be amended to enable the GMC to notify all interested parties.

5(9) & 24	It would be helpful to know more about the circumstances under which the GMC would deem it appropriate for referrals through to case examiner and on to a Tribunal to be withdrawn. The decision to refer a case on for adjudication is in itself a significant step in the process, and one that should provide certainty to all parties where possible. We see the value in increased flexibility here in specific circumstances, however, we would like to see clear public guidance setting out criteria, to bring certainty, clarity, and consistency to these decisions.
General	Legal input – we would like to know more about how case examiners would avail themselves of legal advice on a decision, particularly if they are making decisions alone. Rules 52 and 53 set out a framework for legal input into Tribunal decisions, and it is unclear how this will be managed for decisions by case examiners, who will have the same suite of powers as Tribunals.
Adjudication – case management	
26	The consultation document (p45) makes reference to case managers being allowed to 'resolve a wider range of issues in advance of the hearing', thereby enabling 'the hearing itself to be focused solely on the issues which continue to be the subject of dispute between the associate and the GMC'. We understand the reasoning behind this, however we would like to understand more about how this would work in practice – case management should be distinct from decisions about how to prosecute the case. Would it still enable and support the Tribunal to delve into matters that the case manager has apparently 'resolved' ahead of time? We would also like to understand more about the case management process in practice: • In what circumstances will matters be referred to the different case managers outlined under rule 26(1)? • Will case managers referred to at rule 26(1)(a) have access to legal advice? If not, it will grant case managers, with no apparent access to legal advice, wider case management powers including the ability to determine legal arguments on the papers, which will have an impact on the hearing. Where there may be a dispute and complex legal arguments may need to be made, without legal advice there is a significant risk of something going wrong. • It appears that the case manager will be able to set the procedure that a tribunal must follow to reach a decision, which then could fetter their discretion as to the hearing procedure. • Although rule 26(7) gives a discretion to the tribunal to determine that the directions are not binding, this must be in circumstances where there has been a material change in circumstances or where it is not in the interests of justice for directions to be binding. Nevertheless, the Tribunal can only depart from these

	directions in these limited circumstances and will require them to make a separate decision on directions imposed on them. • Except in relation to preliminary legal arguments under rule 36(2), we could not identify an option for case managers to refer decisions on directions to the tribunal at the substantive hearing, at a preliminary hearing, or to another case manager i.e. the tribunal as a case manager under rule 26(1)(b) or (c). • Where a registrant wants a pre-hearing meeting before the tribunal, will there be an option for this? We note there is a right where there is a review of a final order but could not see that this also applied to case manager decisions. • In what circumstances is it envisaged that a case manager's decision on directions will be made on the basis of the papers only, and not at a pre-hearing meeting? Finally, we would also like clarity on whether case manager decisions will be included within the final panel hearing decision. This will have an impact on our ability to challenge Tribunal decisions through s.29.
Adjudication – vulnerable witnesses	
38	We were pleased to see that the provisions relating to vulnerable witnesses do not prescribe narrow definitions of vulnerability, and generally provide greater flexibility for witnesses to be treated in ways that are sensitive to their needs. It would be helpful to know more about when vulnerability will be considered. It is often dealt with as a pre-hearing matter but it would be more beneficial if addressed earlier to better support witnesses throughout the process. The idea of certainty and creating a safer and more predictable space is also in line with trauma informed care. Will 'all the circumstances of the case' (38(4)) be expanded in policy? In order to effect change, it will need to be clear that this goes beyond merely aspects of the witness themselves (i.e. inherent vulnerability), but also takes into account situational vulnerability, which may be permanent or temporary. The Civil Procedure Rules include words to this effect to make it clear that this is a more holistic reading. Under 38(5)(b), it would be helpful to know more about what measures may be considered, and how this might be set out in policy. While 'any measures' is wholly apt to recognise that witnesses are not homogenous, any

	policy should aim to emphasise that the purpose of this section is to expand rather than constrict options. For example, this should go beyond things like screens and include e.g. ground rules for cross examination etc. At 38(8) we suggest the addition of wording to require that witnesses views are sought. This would seem to be a gap where the witness voice could be lost. The research carried out as part of the National Institute for Health Research (NIHR) Witness to Harm project on the use of 'vulnerability' in regulator legislation has provided a helpful basis on which to comment on these proposals.[7]
Adjudication – Procedure at an Associates Tribunal hearing to determine an allegation	
42	It would be helpful to know what becomes of a case examiners' findings on facts and impairment as set out in the Terms of the Proposed Outcome under Rule 19, after a case has been referred to a Tribunal. It seems they have the potential to be prejudicial to the Tribunal's findings, and indeed, should the Tribunal's findings differ, this could give rise to concerns about the process.
Adjudication - Record of decisions, recording of proceedings, appointment and constitution of Tribunals	
46(2)	We suggest that this should read 'an accidental slip or omission in the record of a decision', rather than allowing for the decision itself to be amended after the fact.
47	The PSA is not listed here, and we would not want this to amount to a reason not to notify us of a decision. The GMC may therefore want to consider including the PSA in this list, to put the matter beyond doubt.
50 & 51	Rules 50 and 51 of the draft Rules provide that the Associates Tribunal is appointed by the Medical Practitioner's Tribunal Service. That does not of itself mean that the Associates Tribunal is a Medical Practitioner's Tribunal for the purposes of our section 29. As such it is recommended that additional drafting is included as follows: Suggested new Rule 50(5) "*For the avoidance of doubt, the Associates Tribunal is a Medical Practitioner's Tribunal for the purposes of section 29 of the NHS Reform and Health Care Professions Act 2002*."
Review of Final Measures	

[7] https://wels.open.ac.uk/research/witness-harm-holding-account

56(1) & (2)	It is unclear how the GMC's general power to direct a review in Article 14 is intended to work where the case examiner or the Tribunal has directed a review. Rules 56(1) and (2) refer to those powers but do not specify how, if at all, they operate in relation to each other. So it is unclear whether the GMC intends to be able to direct a review of a Final Measure in advance of or in addition to a review by the case examiner or the Tribunal. As the Rules are drafted, the GMC could accede to a registrant's request to conduct a review before a directed review has been undertaken and could direct a case examiner to conduct a review that has been directed by the Tribunal. While we welcome the inclusion of these decisions in our jurisdiction, there may be implications for the practical exercise of our section 29 power over *case examiner* reviews of decisions originally made by a Tribunal. Suggested amendments: *Rule 56(2) "Where a direction that the Final Measure be reviewed by the Associates Tribunal has not been made,…"* *Rule 57(1)(a) at the end "…where the Final Measure was imposed by a case examiner;".* *Rule 57(1)(b) at the end "…where the Final Measure was imposed by an Associates Tribunal."*
57(1)	We are pleased to note that reviews of conditions and suspensions will be delegated to case examiners and Associates Tribunals. These decisions carry a high degree of risk, and should be made by decision makers of equivalent status to those making the original decisions. We would welcome more information about how the regulator would decide whether to refer the case to case examiners or a Tribunal, and what equally might trigger a referral from the case examiner to the Tribunal. We note that there is some inconsistency with the consultation document at page 41, where it appears that reviews of existing Interim measures and reviews of final measures will be carried out by default by the case examiners, and only 'in certain circumstances' by a tribunal. There would not appear here to be a separate stage built in for the regulator to decide who to refer the review to. We nonetheless suggest that elements of our guidance on use of accepted outcomes may be helpful to guide such decisions, and will consider this as we review the guidance in response to the consultation responses we have received.

	It should be noted that the PSA will have the right to challenge case examiner and Tribunal review decisions made under Art 14(2) and (3), under its s.29 powers, and the new s.29(1)(hb).
60(1)(b)	We would welcome clarification as to the circumstances in which a measure would be revoked rather than allowed to expire.
62(2) & 64	At page 48 of the Consultation document, the GMC refers to timeframes and the registrant's right to request that a review of the order be carried out by the tribunal – although this appears to be only when they reject a case examiner proposed outcome. Rule 64 also enables the case examiner to request further information. Where the registrant decides to request a tribunal hearing to review the order or where further information is sought by the case examiner, which the registrant will have the right to comment on before it is considered by the case examiner, there is likely to be a delay. How will this be managed where the order may lapse/expire prior to conclusion of the review? As per our feedback above, having these options adds time and complexity to a process that is time-sensitive and carries a high public protection risk.
65	We suggest that this Rule might cross-refer to the specific referral decisions to which it applies. Without this, the extent of this power is unclear. Page 49 of the consultation document explains that the regulator may withdraw the referral 'because it's become possible for a case examiner to conclude the matter without a hearing'. It would be helpful to have clarity about what this means in practice, so we can be assured it would not be used to undermine the case examiner's discretion to refer to a tribunal where there has been no material change in circumstances.
General Medical Council (Revisions) (Anaesthesia Associates and Physician Associates) Rules 2024	
2(1)	It is helpful that the GMC has given the PSA as an example of an eligible person in the consultation document (p58) when it comes to requesting a revision. However, the Rules should make explicit that the PSA will always be considered an eligible person for revision of decisions under 10(3) other than a decision to refer a matter to a Panel.

	We propose the following wording: *2(1) In these Rules…* *"eligible person" means…* *(c) where the request concerns a decision under article 10(3)(a) or 10(3)(b)(i), the Professional Standards Authority for Health and Social Care;*
4(1)	We note that in the Fitness to Practise process, no decisions will be 'revisable' prior to the decision about whether to refer a case to the case examiners, which would appear to be equivalent to the real prospect test currently applied by case examiners and investigating committees. Currently, the GMC's Rule 12 process enables people to challenge decisions to close cases at any point in the process up to and including the decision at the end of the investigation stage (currently taken by case examiners, but to be taken ahead of referral to case examiners under the new model). We would welcome clarity on whether, in practice there we will be a route for complainants or other interested parties to challenge a decision to close a case before the decision point leading to referral (or not) to the case examiner – assuming such decisions will exist under the new model.
6(1)	We would have liked to see more detail on how the power to revise a decision might operate in practice. Rule 6(1) provides that the GMC may revise a decision by revoking or varying it. As regards case examiner fitness to practise decisions, the following could occur: • The case examiner finds no impairment and no action and the GMC revokes that decision. It is unclear what action would follow from such a revocation and who would reconsider impairment. • The case examiner finds no impairment and no action and the GMC varies that decision so as to impose a warning. It is unclear who would decide on the terms of such a warning. • The case examiner finds impairment and imposes a Final Measure and the GMC revokes that decision. It is unclear what action would follow from such a revocation and who would reconsider impairment.

	• The case examiner finds impairment and imposes a Final Measure and the GMC varies that decision to impose a different Final Measure. It is unclear who would take that decision. We note that Rule 6 gives the GMC two options for revisions: revoking or varying. But by our reading, nearly all the revisable decisions (4(1)) are binary decisions to register or not register, to remove or not remove, or that someone's fitness to practise is impaired. With these decisions, it is not clear what the distinction is between revoking and varying. It would be helpful if the rules could make clear whether the power to revise a decision under s10(1)(b) means that a decision *not* to refer to a case examiner is revisable, especially in light of comments on Rule 4(1) above.
10(1)	The PSA is not included in the Rules that provide rights to be notified after decisions under Article 15 have been taken. Amending the Rules so that we are notified of any revision would avoid the need for us to separately request a copy of the revised decision on every occasion. It is recommended that the provisions are amended to have that effect. We propose the following wording: *10 (1) The Regulator must…notify:…* *(c) the Professional Standards Authority of:* *(i) the revision;* *(ii) the date from which the revision is effective;* *(iii) the reasons for the revision.*
General	There is no requirement within the Revision Rules for the GMC to give reasons for its decision to revise a decision where that decision is made of its own initiative. There is a requirement (in Rule 7(4)) that the GMC gives reasons for decisions not to revise a decision where a request for revision has been made but not where it decides to revise a decision where such a request has been made. We suggest that the GMC should be required to give reasons for all decisions made in relation to the revision of decisions.
AAPOA 15(2)	The test for revision of case examiner decisions would deny the regulator the opportunity to look again at an outcome in the light of information that was available at the time but the GMC were unaware of and/or was not considered by the CE, that would have made a material difference to the outcome. This is an important function

	of the GMC's current Rule 12 facility, and not one that could be remedied by any changes to the Rules. We will be raising this concern with DHSC.
General Medical Council (Internal Appeals) (Anaesthesia Associates and Physician Associates) Rules 2024	
5(2)	As set out in our opening comments, the fact that registrant appeals can be brought against a case examiner Final Measure where it is deemed 'unjust' only serves to highlight the inadequacy of the grounds for revision on an error of fact or law as the only public protection measure. Providing such an appeal route for registrants is a recognition that a test based on an error of fact or law does not enable a review of the substance of the decision. If an appeal route is needed to rectify injustices from the registrant's perspective, we would argue that it must also needed address a decision that is not sufficient to protect the public, without there having been an error of fact or law. It is precisely this asymmetry that our s.29 powers were created to address, over twenty years ago.[8]
General (cross-appeals)	"Steps taken" by a Panel under Article 13(1) and by the GMC under Article 14(3) are subject to the PSA's section 29 jurisdiction by virtue of amendments made to section 29 by the AAPAO, and are also subject to the rights of appeal under Articles 16(1) and 17(1) of the AAPAO. It is unclear how the PSA's jurisdiction in respect of those decisions will interact with such appeals. No reference is made in Articles 16 or 17 of the AAPAO or the Appeals Rules to the PSA's ability to refer those decisions to Court. It is therefore possible that the PSA could refer a decision to Court that is the subject of an appeal pursuant to Article 16 or 17 of the AAPAO. It is also unclear: • Where the PSA has appealed a decision under section 29 but that appeal has not been determined, what effect if any that would have on the status of any decision subject to appeal under Article 16 or 17 of the AAPAO or what effect the making of that appeal decision would have on the extant section 29 appeal. As noted below, the making of a decision under Article 16 could have the effect of producing a new decision that falls outside the PSA's jurisdiction. It is arguable that the section 29 appeal would fall away by operation of law (as the decision to which it relates no longer existed, where the appeal was allowed) but this is by no means certain;

[8] https://publications.parliament.uk/pa/cm200102/cmstand/a/st011213/am/11213s03.htm

	• Where the PSA has successfully appealed a decision but an appeal under Article 16 or 17 of the AAPAO had not yet been determined, what effect the appeal decision would have on the extant Article 16 or 17 appeal. It is arguable that the Article 16 or 17 appeal would fall away by operation of law (as the decision to which it relates no longer existed) but this is by no means certain.
AAPAO Art.16 (1)	The PSA will have s.29 jurisdiction over decisions, whether made by case examiners or Tribunals, to review conditions and suspensions. It will not, however, have equivalent jurisdiction over internal panel appeal decisions under article 16(5) to quash such a decision, or substitute it. It is also unclear whether the PSA would have the s.29 power to challenge Article 13(1) decisions remitted to a decision-maker other than a Tribunal under 16(5)(d), where the PSA had the ability to appeal the original decision. This will undermine our s.29 jurisdiction and create a public protection loophole. We will be raising this concern with DHSC.
General Medical Council (Education and Training) (Anaesthesia Associates and Physician Associates) Rules 2024	
Curriculum approval	
3(5) and 4(6)	3(5) states that the GMC must (rather than has the power to) approve a curriculum if it meets the Standards (note equivalent for courses at 4(6)). This puts a significant burden on the Standards to address all relevant risks. The GMC would need to consider how it might address significant risks that could arise but fall outside the scope of the Standards, and whether it would be more appropriate in terms of patient safety to maintain a degree of flexibility over the final decision on approval. The GMC's curriculum and course standards documents include 'standards' and 'requirements'. The GMC will need to be clear on what the status of the 'requirements' is, as the Rules do not mention them.
3(6)	3(6) sets out three circumstances in which the GMC may – rather than must - refuse to approve a curriculum. With regard to 3(6)(c) and (a) in particular (the third and first circumstances) it is unclear why the regulator would retain the flexibility to grant approval through use of the word 'may', unless it is because the GMC is able to attach conditions to approval. However, the powers to attach conditions appear to be tied to ongoing quality assurance under Rules 6 & 7. Whereas Rule 4(7) specifically gives the GMC the power to give initial approval with conditions to a course, there is no equivalent paragraph under Rule 3.
Course approval	

4(3)(c) and 4(4)	4(4) effectively states that, where an applicant for course approval does not make clear in any published material relating to a course that the course is not approved, the regulator may – rather than will - take this into account when determining the application for approval. It may be that there are acceptable reasons for the regulator to approve a course even where the requirement of this paragraph is not met. It is, however, unclear why there would not be an imperative ('will' / 'must') to take this into account, even if ultimately the outcome is still approval / approval with conditions. We also note that the GMC has chosen to clarify here that it may only take into account non-compliance with 4(3)(c) and not with 4(3)(a) or (b). Therefore, we would welcome confirmation on whether this is because these matters (4(3)(a) and (b)) fall into its decision-making under 4(5) to (7).
4(7)(a) and (b)	There may be a discrepancy between the language used in 4(7)(a) and (b) and 4(1)(a)(ii) and (iii). 4(7) appears to be relevant only to courses that are already running and now seeking approval. The language used in 4(1)(a)(ii) and (iii) implies that Rule 4 applies to courses being set up, as well as those already established (although not yet approved).
Monitoring and quality assurance	
6(2)(a) to (d)	6(2)(a) to (d) define what monitoring and assurance activities undertaken by the regulator may include. We are concerned that the drafting may not allow sufficient flexibility for any other monitoring and assurance activities that the regulator may wish to undertake and that the activities would be limited to those defined in (a) to (d). Other possible monitoring and assurance activities might include: a form of virtual inspection; feedback from patients / service users.
6(3)(a) to (d)	6(3)(a) to (d) enables - rather than obliges - the regulator to publish certain documents relevant to its quality assurance processes. It would be useful to understand under which circumstances the regulator would justify withholding these types of documents from publication. We also seek reassurance that 6(3)(a) to (d) will allow sufficient flexibility to include any other appropriate documents to publish, rather than limiting them to the list in (a) to (d).
Revocation of approval	
9(1)(b)	9(1)(b) enables the regulator to revoke approval when it is not satisfied on the basis of information or evidence obtained under Rule 6(1), 6(2) or 7 that the curriculum or course meets the standards or requirements determined by the regulator.

	We seek clarification on whether the GMC would have the power to investigate concerns about the delivery of a course or curriculum. There is no specific mention of concerns in these Rules. We seek reassurance that 9(1)(b) would enable the regulator to take action in response to any significant concerns that are raised with it, which might not be viewed as part of the monitoring and quality assurance process. We would also be interested to understand the rationale for why approvals are not time-bound.
General	
	Organisations subject to ongoing monitoring / quality assurance appear to be referred to as 'applicants for approval'. We found this wording unclear.
	It would be helpful to know if courses that are yet to start can still apply for approval on the basis of the paperwork. If this is the case, will such courses only achieve approval subject to the condition of, for example, the completion of the first cohort of students?
Standards for PA and AA curricula	
General	
	The GMC's curriculum and course standards documents include 'standards' and 'requirements'. The GMC will need to be clear on what the status of the 'requirements' is, as the Rules do not mention them.
Theme 1: Purpose of the curriculum	
CR1.2 and CR1.3	CR1.2 requires the organisation / applicant for approval / curriculum developer to describe the knowledge, skills and capabilities expected of a graduate. The Standard under which this requirement sits is 'The curriculum has a stated and clear purpose based on practice within a multi-disciplinary team, service, and patient and population needs'. Therefore, it might be helpful to tighten CR1.2 by adding at the end of it 'in order to meet patient and population needs' or similar. This should help ensure that the knowledge, skills and capabilities of a graduate are focused tightly on patient and population needs. This might also apply to CR1.3 which requires the organisation / applicant for approval / curriculum developer to describe the high-level outcomes. These outcomes should be mapped onto the patient and population needs.
Theme 2: Governance and strategic support	
CR2.5b	CR2.5b requires input from patients, relevant patient groups, carers and lay people.

	This requirement may be improved by adding at the end of it 'including those who share protected characteristics' or 'including people from a diverse range of backgrounds'. The second would take into account diversity in its broader sense, including socio-economic group.
CR2.5	Our understanding is that there will not necessarily be a public consultation on (changes to) the proposed curriculum. CR2.5 requires engagement and consultation to be proportionate to the change being made and tailored to the relevant group. If the change is significant or a new curriculum is being submitted, we would be interested to know if the GMC will expect the curriculum developers to undertake a public consultation exercise.
Theme 3: Programme of learning	
CS3.1	Under this Standard, the GMC may wish to consider including a requirement for curriculum developers to show how, through the outcomes, Associates will be equipped, when they enter the workforce, to provide care to a diverse population in a way that aims to eliminate health inequalities. We would also suggest the GMC make a clear requirement here for curriculum developers to demonstrate how the learning outcomes will support working within a multi-disciplinary team, and meet service, and patient and population needs.
Standards for the delivery of PA and AA pre-qualification education	
General	
	The GMC's curriculum and course standards documents include 'standards' and 'requirements'. The GMC will need to be clear on what the status of the 'requirements' is, as the Rules do not mention them.
	The applicants for these postgraduate programmes will come from diverse professional backgrounds and have varying experience, training and skills sets. The GMC does not stipulate here standards for entry requirements for the courses, which allows the providers flexibility to admit those they deem suitable for their particular programme. In light of this, it will be essential for the Standards in this document to show clearly how the GMC will be assured that providers ensure patient safety during the programme, as well as provide programmes that can take into account the differences in backgrounds of the learners. This is a postgraduate programme which enables a change in profession for people from varying backgrounds; this may pose a risk which should be mitigated through the Standards.
Specific standards	

Standard 3 – Requirement 3.4	R3.4 requires organisations to make reasonable adjustments for disabled learners, in line with the Equality Act 2010. The corresponding Note 3 explains that the Equality Act 2010 does not apply to Northern Ireland. Reference is made to the two relevant pieces of legislation in NI, but there is no requirement for any course providers to comply with the pieces of legislation. Where a course is run in NI, we would be interested to know how the GMC will be satisfied that providers make reasonable adjustments for learners with disabilities, health conditions or impairments.
Standard 3 – Requirement 3.4	Standard 3 is about supporting learners. R3.4 requires organisations to make reasonable adjustments for disabled learners, in line with the Equality Act 2010. We would suggest that the GMC broaden the definition of those requiring support beyond that set out in the Equality Act (for example including those with health conditions or impairments) and look at how providers could actively encourage and support people with disabilities and health conditions. In terms of our own approach to reviewing the regulators' performance on Equality, Diversity and Inclusion (Standard 3 of our Standards of Good Regulation) we expect regulators to comply with their legal responsibilities but also to be prepared to go beyond the bare legal minimum where there is evidence of unfairness they could try to address, or potential benefits to public protection.
Standard 5 – Requirement 5.1(a)	In its current form, Requirement 5.1(a) is difficult to follow.
Standard 5 – Requirements 5.5 and 5.6	The last sentence in Requirement 5.5 is the same as the first sentence in Requirement 5.6.