EXPLANATORY MEMORANDUM TO

THE OFFICE OF THE HEALTH PROFESSIONS ADJUDICATOR REGULATIONS 2009

2009 No. 2722

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 These Regulations make provision with regard to membership of the Office of the Health Professions Adjudicator ("the OHPA").

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4. 1 These Regulations set out the number of executive and non-executive members which the OHPA is to have, and prescribe the requirements that a person who is to be appointed as a member of OHPA must satisfy. It is necessary to make these Regulations to enable the first appointments of executive and non-executive members of the OHPA to be made in due course by the Privy Council in accordance with paragraphs 4 and 8 of Schedule 6 to the Health and Social Care Act 2008.

5. Territorial Extent and Application

5.1 This instrument applies to all of the United Kingdom.

6. European Convention on Human Rights

6.1 As this instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

- ***What is being done and why***

7.1 The OHPA is a new independent body established by provisions in the Health and Social Care Act 2008 ("the 2008 Act") (which are yet to be commenced). It will make decisions on fitness to practise cases referred to it by the General Medical Council (GMC) and subsequently

the General Optical Council (GOC). The Department of Health's longer-term policy is to enable the other healthcare regulators to move to independent adjudication, by means of referring their fitness to practise cases to OHPA to be decided upon, if they wish in the longer term.

7.2 The overall objective underlying the establishment of OHPA is the need for a clear separation between the investigation of concerns about the fitness to practise of doctors and, in time, other health professionals, and the process of determining whether a professional's fitness to practise is impaired. Independent adjudication is designed to increase the confidence of the public and professions in the impartiality of decision making.

7.3 The intention is that OHPA will come into existence (by means of section 98 and various other provisions of the 2008 Act being commenced) in early 2010, but will not take on its substantive functions of adjudicating on cases referred to it by the GMC until 2011. The interim period will be used by OHPA to prepare to take on these substantive functions.

7.4 These Regulations, in setting out the number of executive and non-executive members that OHPA is to have and the requirements that a person to be appointed as a member of OHPA must satisfy, pursuant to the powers in paragraphs 5 and 7 of Schedule 6 to the 2008 Act, are a necessary precursor to any first appointments of members to OHPA being made by the Privy Council. The intention is that, once these Regulations come into force, executive and non-executive members will be designated to become members of OHPA once OHPA comes into existence, so that work on preparing OHPA for its establishment and the carrying out of its substantive adjudication functions can begin. Walter Merricks has been appointed as OHPA Chair designate and takes up post on 02 November 2009.

8. Consultation outcome

8.1 A public consultation on a draft of these Regulations took place over a 12 week period between 20 March 2009 and 19 June 2009. Overall, the response supported the content of the draft Regulations. However, in answer to the question asking if an initial board size of three (consisting of the chair, one non-executive member and one executive member) was appropriate, there was a degree of variance in responses. Whilst several respondents felt that such a board would be sufficient during the early stages of OHPA's existence, there was a more general view that a larger board was needed to ensure that the full range of expertise required for proper governance could be assembled. Having considered this issue further, the decision was taken that it would be preferable for a wider skills set to be represented on OHPA's board during the development of the new body.

8.2 An increase in the number of non-executive members from the initially proposed number of one to three will enable a fuller range of expertise

to be recruited prior to the OHPA becoming fully operational, ensuring that such skills are available throughout the establishment of the new body. Accordingly, the Government decided to increase the size of the initial board to five.

8.3 With regard to the periods of office of members, there was widespread agreement that the length proposed of a maximum of 8 years in any 20 year period was appropriate in that it mirrored the terms of office of the health regulators themselves.

8.4 The proposed reasons for disqualification from membership of OHPA attracted a range of comments, with the majority supporting the proposals. Some respondents asked whether convictions should ever be regarded as spent for the purpose of disqualification. In considering this, the conditions applicable to other health regulators were examined and the Government decided that it would not be appropriate to regard convictions as spent for other purposes but not spent for the purposes of qualifying for membership of OHPA.

8.5 Some respondents felt that to bar members of registered professions from eligibility for membership of OHPA was unduly restrictive or would prevent OHPA from accessing the experience of such individuals.

8.6 OHPA will discharge its adjudication functions through fitness to practise panels, which will include a professionally qualified member, and clinical and other specialist advisers may also be appointed to advise fitness to practise panels. Professional expertise will therefore be available to OHPA in the carrying out of its adjudication functions. Therefore, the Government considers that it would be preferable to avoid any potential conflict of interest that may arise by involving registered professions in OHPAs board by disqualifying members of specified professions from membership of OHPA..

8.7 The draft Regulations were amended to reflect the change to the size of the initially proposed OHPA Board.

8.8 A detailed explanation of the Department of Health's policy response to the opinions expressed by respondents to the consultation will be published on the DH's website.

9. Guidance

9.1 The Department of Health has not issued any guidance in relation to these Regulations.

10. Impact

10.1 There is no impact to business, charities or voluntary bodies.

10.2 There is no impact on the public sector.

10.3 An Impact Assessment has not been prepared for this instrument. However, a copy of the Impact Assessment prepared for the creation of the Office of the Health Professions Adjudicator in February 2009 is attached for information.

11. Regulating small business

11.1 The legislation does not apply to small businesses.

12. Monitoring and Review

12.1 Within 2 years of OHPA becoming operational, the Department of Health will review the impact of the Regulations in considering the effectiveness of the White Paper implementation in respect of OHPA,

13. Contact

13.1 Tracey Eckersley at the Department of Health Tel: 0113 254 5789 or email: tracey.eckersley@dh.gsi.gov.uk can answer any queries regarding the instrument.

Summary: Intervention & Options

Department /Agency:	Title:	
Department of Health	**Impact Assessment of creation of the Office of the Health Professions Adjudicator**	
Stage: Final	**Version:** 4	**Date:** 17 February 2009
Related Publications: Trust, Assurance and Safety, The Regulation of Health Professionals in the 21st Century AND Health and Social Care Act 2008		

Available to view or download at:
http://www.SEE EVIDENCE BASE FOR LINKS

Contact for enquiries: Mike Lewis **Telephone:** 0113 254 6146

What policy options have been considered? Please justify any preferred option.



Summary: Analysis & Evidence

Policy Option:	Description: **Impact Assessment of creation of the Office of the Health Professions Adjudicator**

COSTS

ANNUAL COSTS

One-off (Transition)	**Yrs**
£ 4.2M	2
Average Annual Cost (excluding one-off)	
£ 3.0	

Description and scale of **key monetised costs** by 'main affected groups'

Total Cost (PV) **£ 21.6M**

Other **key non-monetised costs** by 'main affected groups'

BENEFITS

ANNUAL BENEFITS

One-off	**Yrs**
£	
Average Annual Benefit (excluding one-off)	
£	

Description and scale of **key monetised benefits** by 'main affected groups' The benefits are non monetised

Total Benefit (PV) **£**

Other **key non-monetised benefits** by 'main affected groups' Increased fairness in adjudication and significantly increased public confidence in the system through its majority legal and lay membership. See evidence base for further details.

Price Base Year	Time Period Years 5	**Net Benefit Range** (NPV) **£**	**NET BENEFIT** (NPV Best estimate) **£ -21.6M**

What is the total annual cost of enforcement for these organisations?	£ see evidence
What is the value of the proposed offsetting measure per year?	£
What is the value of changes in greenhouse gas emissions?	£

Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

Links for related publications

Trust, Assurance and Safety, The Regulation of Health Professionals in the 21st Century
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

Health and Social Care Act 2008
http://www.opsi.gov.uk/acts/acts2008/pdf/ukpga_20080014_en.pdf

Enforcement costs

Enforcement achieved via legislation under Health and Social Care Act 2008

Rationale for Government Intervention

1. Currently each health professions regulatory body has powers and procedures to investigate any concerns about the fitness to practise of persons practicing the profession(s) it regulates. Each of the regulators investigates complaints, decides which cases should go to a hearing, prepares cases for the hearing and adjudicates (i.e. makes decisions and issues sanctions in respect of the health professionals it regulates).

2. The Government is concerned that these adjudication panels may be compromised by a perception of partiality, either for or against the profession they regulate A number of councils have made changes to address these concerns, or are planning to do so, by prohibiting council members of the profession from sitting on fitness to practise panels to demonstrate the panel's independence.

3. However, Dame Janet Smith recommended in the Shipman Inquiry, 5th report, that in the case of the medical profession there should be a clear separation of adjudication from the General Medical Council's other functions. The Government supports this view, and considers that the separation of investigation, prosecution and adjudication is a fundamental principle of modern legal and judicial practice.

4. The Chief Medical Officer has also recommended that in the case of the GMC the separation of investigation and prosecution from adjudication is essential to ensure public and professional confidence in the independence of the decisions made by the adjudicators.

Aims and Objectives

5. The main aims of changing the adjudication system for health professionals are to:

- Ensure that, in future, adjudication in the case of doctors and professions regulated by the General Optical Council, will be undertaken by a separate body which will be demonstrably independent from the regulatory body with responsibility for investigating any concerns about a professionals fitness to practise;

- Establish the independent adjudicator with an initial remit to adjudicate in respect of doctors' fitness to practise, in order to provide for an incremental, managed transition to independent adjudication in relation to all healthcare professionals.
- Over time, to harmonise processes of adjudication for the various regulated healthcare professions, where it would be appropriate to do so.

Options Analysis

6. Following the recommendations made in the Shipman Inquiry's Fifth Report, a number of options for delivering independent adjudication for doctors and the other regulated healthcare professions were considered. The option of doing nothing was ruled out on the basis that an independent inquiry into the activities of Britain's most notorious serial killer has recommended the need to separate adjudication from investigation. The Government wishes to ensure that every possible measure to assure public and professional confidence in the system of health professions regulation has been taken.

7. The option of mandating a move to independent adjudication for all regulated healthcare professionals was ruled out at this time because it was considered more desirable to test out independent adjudication for doctors first and then to ensure a managed transition to independent adjudication for other healthcare professions in future, should there be a desire to extent independent adjudication further.

Preferred Option: Independent adjudication for doctors, other professions to have internal separation with the option to transfer their adjudication functions in the future, if desired by them.

- Full separation of adjudication from GMC into a new body
- Other professional regulators will move to full internal separation of adjudication with no council members on panels. Panel members training to include awareness of and competence in equality and diversity issues. Panellists would be drawn from a diverse group.
- Other professional regulators could choose to move to the new body subject to Parliamentary approval

8. The Department's preferred option was selected, after analysis of the consultation *Healthcare professional regulation: Public consultation on proposals for change* carried out in 2006 , because it gives a clearly visible separation of functions for all regulators and complies with Dame Janet Smith's recommendation for the regulation of doctors.

9. In response to this consultation, the White Paper '*Trust, Assurance and Safety*' in February 2007 set out the Government's intention to establish independent adjudication for doctors in the first instance, with other regulators given the option of following suit.

10. Following this, the legislative framework for a new independent adjudicator, to be known as the Office of the Health Professions Adjudicator (OHPA) was set out in the Health and Social Care Act 2008. It contains provisions relating to both the GMC and the GOC, as the GOC has requested that it transfer its adjudication to OHPA at the earliest opportunity. This is in line with the Department's longer term policy of enabling the other regulators to move to independent adjudication if they wish. The body will adjudicate on Fitness to Practise cases for, initially, the General Medical Council.

Implementation of the Office of the Health Professions Adjudicator

Recommendations of the Tackling Concerns Nationally Working Group

11. The "Tackling Concerns Nationally" Working Group was set up following publication of the White Paper to look at more detailed structures and procedures for the establishment of OHPA. In its report *Establishing the Office of the Health Professions Adjudicator,* the Working Group made a series of recommendations which take forward the implementation of this policy.

12. The majority of recommendations made have been assessed as having no cost implications. However, the following table sets out those recommendations which do, or which could have cost implications. In the majority of cases, where recommendations have associated costs the decision about if/how to implement the recommendation is for OHPA to take.

No	Recommendation	Cost	Benefits
10	Building on the provisions of the Health and Social Care Act 2008, OHPA should consider whether it would be desirable to make rules that enable additional members of the panel to be appointed for hearings that are likely to be longer than usual. This would be in order to ensure that there would still be a quorum if one or more members of a panel were required to step down after a hearing has begun.	The decision to introduce such rules would be for OHPA to take. It is not possible to estimate costs at this stage until draft rules are available.	Potential to streamline conduct processes by reducing number of occasions on which a case is delayed by panel members temporarily stepping down. Could translate into some efficiency savings.
13	Plans for the transfer of the GMC's role in adjudication to OHPA should take account of the relatively large number of panellists that will be required to adjudicate on cases of medical fitness to practise and the desirability of retaining experienced GMC panellists in OHPA's pool, where they have a satisfactory performance record. However, there should be no automatic prospect of transfer to OHPA as OHPA will need to satisfy itself that persons appointed to its panels are suitable.	This is ultimately a decision for OHPA to take. Individual interview / assessment of panellists would have a cost associated with it.	The measure would ensure that all fitness to practise panellists remain fit for purpose.
14	There should be a pilot scheme to test the benefits of using legally qualified chairs, as recommended by Lady Justice Smith. OHPA should consider making provision	This recommendation is ultimately for OHPA to make a decision on. It is not possible to predict costs with any degree of accuracy until	Any proposals for introducing legally qualified chairs would be properly tested and costed.

	in its rules to test, by way of a pilot scheme, the use of legally qualified chairs. This would assist in defining the circumstances in which chairs with specific competence, or specialised knowledge, should be appointed. This would include the consideration of whether, for example, there are circumstances in which either legally qualified, medically qualified, and lay chairs would be beneficial.	proposals for a pilot have been drawn up.	
15	OHPA should have regard to the recommendations of the working group established by the GMC to consider issues of case management and procedural issues in hearings.	This recommendation is ultimately for OHPA to implement.	Could deliver some efficiency savings, but not possible to cost until the working group has reported.
17	OHPA should introduce a system of annual appraisal of performance of its panellists. In introducing such a system, OHPA must ensure that the independence of panellists' decision-making is not compromised. There should be transparent criteria by reference to which the performance of individual panellists is assessed. OHPA should seek advice from regulators and from the Judicial Studies Board about the design of a system of appraisal for panellists.	There would be some costs associated with introducing appraisal. On the assumption that there would be some form of peer review for around 300 panellists, the estimated amount of effort would be two hours of assessor time and 1 hour of panellist time per appraisal. This could be equated to one half day assessment If the average panellist were to receive £300 per day, this could equate to 300 x £150 = £45,000 per annum	The benefits of introducing appraisal would include greater assurance that all panellists remain up to date.
20	The formula that OHPA will apply to determine its fee should take account of the complexity and the likely duration of cases as well as the volume of cases.	At this stage it is not possible to assess costs until a detailed formula has been drawn up.	Because of the complexity, medical fitness to practise cases last on average longer than those of other regulators. The proposal would ensure a fairer distribution of costs across the regulators than a fee model based on a flat rate per case.
23	The bodies regulating healthcare professionals should collect and	The cost of this recommendation will need	This recommendation is accepted in principle and

monitor information relating to equality and diversity as part of routine collection of data. Information relating to equality and diversity should also be collected and monitored in respect of healthcare professionals against whom complaints are made to the bodies regulating healthcare professionals and referrals for adjudication, including referrals to OHPA.

to be assessed in conjunction with the bodies concerned but it is believed that it will be marginal as part of the overall drive to improve matters in this area.

we will be discussing how this might be implemented with those concerned.

Benefits

The introduction of an independent adjudicator brings a range of non-monetised benefits. The chief benefit relates to the separation of investigation, prosecution and adjudication as a fundamental principle of modern legal and judicial practice.

By ensuring this, it will be possible to address the perceptions of partiality, either for or against the registrants involved, thus restoring public and professional confidence in the role of the bodies concerned in ensuring public and patient safety.

The move by other regulators to an internal separation of their adjudication function will move towards addressing such perceptions also.

Further benefits include greater standardisation in case management and the potential for achieving greater consistency in the sanctions applied in fitness to practise cases, as more bodies adopt an internal separation or move to adjudication of cases by OHPA.

Costs

Option 1 – Adjudication remains with Regulatory Bodies – No change

Option 2 - GMC adjudication independent, remainder to have internal separation with the option to transfer their adjudication functions in the future, if desired by them.

Costs analysis have been based on the Price Waterhouse Coopers report *Office of the Health Professions Adjudicator (OHPA) A Cost Review prepared for the General Medical Council (GMC)* and are subject to refinement in light of ongoing discussions and analysis.

	OHPA profiling All figures in £000	2009/10	2010/11	2011/12	2012/13	2013/14
1	GMC residual costs - subject to detailed review in light of changes in circumstances			2400	2400	2400
2	Project manager	558	350			
3	PC regs on board composition					
4	Appointments commission	15				
5	Advertising	75				
6	A1 Chair	76	114	114	114	114
7	A2 Chief Exec	90	180	180	180	180
8	A3 Additional non exec Board members	21	126	126	126	126
9	Secretarial support	25	50	50	50	50
10	Finance Director	55	110	110	110	110
11	Finance Team	84	168	168	168	168
12	FTP Director	55	110	110	110	110
13	Research - procedural rules development	150	100			
14	Staff training 2010/11 based on 2 months salary for new staff, subsequent years based on 2 weeks	25	408	75	75	75
15	Recruitment of additional Staff costs	60	300	0	0	0
16	Staff costs					
17	IT staff	100	374	374	374	374
18	receptionists		40	40	40	40
19	Resources manager		43	43	43	43
20	HR & payroll	150	276	276	276	276
21	Case liaison		65	65	65	65
22	Legal staff					
23	Legal manager		110	110	110	110
24	Legal team member		78	78	78	78
25	Paralegal		46	46	46	46
26	Comms and publicity	26	107	107	107	107
27	Existing GMC staff costs on transfer			2548	2548	2548
28	Redundancy costs		250			
29	Appeal costs - physicians			152	152	152
30	Appeal costs - GMC			30	30	30
31	Accommodation search	100				
32	Accommodation additional London	70				
33	Accommodation refurbishment for GMC adjudication function - London	1550	1100			
34	Accommodation costs of GMC function 1 year contract - London 16ksq ft	1150	1150	1150	1150	1150
35	Accommodation costs of GMC function 1 year contract - Manchester 30K sq ft		600	600	600	600
36	IT set up costs	100	1600			
37	IT infrastructure ongoing costs			850	850	850
38	Legal costs	80	80			
39	Audit	23	23	23	23	23
40	T&S					
41	Expenditure incl T&S and conferences	70	120	120	120	120
42	Comms and publicity (non staff costs) related to budget lines below	448	448	448	448	448
43	Publications and Consultation inc stakeholder events					
44	Web presence					
45	Commencement orders					
46	C1 Establishment					
47	C2 Operational date					
48	Consultation					
49	1 procedural rules including					
50	2 financial (SofS regs)					
51	3. panel composition					
52	Panel recruitment		2000			
53	Panel training & assessment		300	135	135	135

54	Direct office costs (2007 GMC)			148	148	148
55	Recharge office costs (2007 GMC)			171	171	171
56	Total Committee costs (2007 GMC)			7300	7300	7300
57	Legal costs (2007 GMC)			1600	1600	1600
58	accommodation costs (outside space as needed) (2007 GMC)			150	150	150
59	Professional fees (2007 GMC)			1	1	1
60	Current GMC Adjudication costs	16367	16367			
	Total Costs	**21,523**	**27,193**	**19,898**	**19,898**	**19,898**

Data Source: GMC figures "Office of the Health Professions Adjudicator (OHPA); A Cost Review prepared for the General Medical Council" PWC

Background

Existing Arrangements

13. Currently Fitness to Practise (FtP) procedures are carried out by the GMC and the GOC under the Medical Act 1983 and the Opticians Act 1989 . The Acts set out the current arrangements for investigation of concerns about the fitness to practise of a doctor of a professional regulated by the GOC.

14. With regard to the GMC, two case examiners carry out an initial investigation and decide what action to take. This may include issuing a warning or referral to a Fitness to Practise panel. If the case examiners cannot agree, or they consider a warning is appropriate, and the doctor refuses to accept the warning, the case will be referred to the Investigation Committee. The doctor's fitness to practise will be looked at in the round and the investigation may include an assessment of the doctor's health and/or performance.

15. If both case examiners decide that a warning is appropriate, the doctor may exercise his/her right to an oral hearing before the Investigation Committee. If the case examiners do not agree on the appropriate outcome, the case will be decided by a meeting of the Investigation Committee.

16. Where a referral is made to a fitness to practise panel, a panel will be convened from a pool of trained panellists which will then hear the case against a professional, determine whether fitness to practise is impaired and determine any sanction. This part of the process is the "adjudication" process.

17. Appeals to the High Court or its equivalent may be made on the judgment of the Fitness to Practise panels by the registrant concerned or by the Council for Healthcare Regulatory Excellence, in cases where the sanction is considered to be unduly lenient.

Problems with the existing arrangements.

18. The present legal framework is designed to produce a fair decision about whether or not a registrant's fitness to practise is impaired, and if so to provide an appropriate and proportionate remedy for the protection of the public and maintenance of confidence in the profession. Fitness to practise (FtP) systems have become complex and highly legalistic, in order to comply with Human Rights considerations for the person accused, and to guard against successful legal challenge (including judicial review).

19. There has been increased media/public interest in the FtP process (investigations & adjudications) as a result of the high profile cases such as Harold Shipman (GP) and Beverly Allitt (nurse) and Bristol, Alder Hey (organisations). The link between local complaints, employment disciplinary, criminal prosecutions, civil litigation and professional FtP cases has been under the spotlight more recently.

20. Because both the investigation and adjudication functions are currently undertaken by a single body, that body is vulnerable to accusations that it is too lenient on the profession that it regulates, or unduly harsh in pursuing professionals. While there is no evidence to support these allegations, perceptions are important and the Government believes that the complete separation of adjudication from the investigation process will provide further assurance that those adjudicating over professionals are entirely impartial.

21. While independent adjudication for all registered healthcare professionals is desirable in the longer term, it is important that the transition to independent adjudication is undertaken in a managed way. It is therefore the Government's intention that independent adjudication should be established for medical fitness to practise cases in the first instance and then extended to the GOC's fitness to practise cases, before decisions are taken about a timeframe for extending independent adjudication to other healthcare professions..

22. Currently there is no overall consistency between the different FtP systems of the health professions regulators. Different professionals involved in the same incident may find their cases being handled in different ways, which is confusing to the body or patient who has referred the matter to the regulator. CHRE has started some work on convergence in FtP procedures and indicative sanctions guidance which will address some of these issues.

23. It has also been claimed that there is too much law in this field. With the existence of nine regulators, each with separate FtP systems, each of which require Rules made under different Acts of Parliament, the process of amendment to close loopholes or reflect new policy, creates a disproportionate burden in terms of duplication of work lack of consistency between legislation and cost.

24. Solicitors and barristers who work with a number of regulators (as prosecutors, defenders, or legal assessors) in FtP cases therefore have to be familiar with a range of different FtP law, as do CHRE when dealing with referred cases and the courts when considering appeals. This all has implications for the overall costs associated with the handling of FtP cases. A further aim of this change is therefore harmonisation.

25. Our conclusion is that the task of adjudicating on concerns about impaired fitness to practise should be given to a single, independent body which will, over time, deal with concerns about all of the regulated health professions. The establishment of a single, independent adjudicator for all registered healthcare professionals would provide an opportunity to simplify and standardize existing arrangements, where appropriate.

26. Detailed research was carried out on this aspect by Judith Allsop and Kathryn Jones on behalf of the Chief Medical Officer and was published on 14 July 2006 as *Quality Assurance in Medical Regulation in an International Context*

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Annexes

Competition Impact Assessment

1. We have identified no competition issues as a result of this policy.

Small Firms Impact Test

2. There is no evidence of any impact on small firms.

Legal Aid Test

3. The number of fitness to practise cases which have gone to appeal are extremely low. Although it is estimated that the number of fitness to practise cases may rise by between 0 and 10% as a result of the introduction of the civil standard, this will have little impact on the work of the courts. There is therefore likely to be little impact on Legal Aid, especially given the nature of the appeal (in relation to ftp proceedings).

4. In addition, it is unlikely that any appellant would be able to meet the means test associated with the provision of legal aid.

Sustainable Development

5. We have not identified any sustainable development issues.

Carbon Assessment

6. We have not identified any carbon related issues.

Other Environment

7. We have not identified any other environmental issues.

Health Impact Test

8. No health impact issues were identified as a result of this policy. We would of course expect better adjudication to help increase patient safety for all people using healthcare services.

Race Equality

9. There has been historical evidence that, in the case of the General Medical Council, international medical graduates (IMGs) were comparatively over-represented at each stage of

the, then, conduct procedures. This was partly explained by reference to the fact that IMGs were over-represented in referrals from public bodies (as opposed to complaints from individuals).

10. Reseach conducted for the GMC in 2005 contained an analysis of outcomes at the initial assessment and case examiner decision stages of the reformed procedures, by reference to the doctor's country of qualification and the source of the complaint or referral. This showed that, for complaints or referrals received in 2005, a greater proportion of those about IMGs were referred for adjudication compared with UK qualified doctors. It also showed, as in the earlier work, that some of the difference is explained by the source of the complaint or referral

11. The GMC is undertaking further work to identify causes for this, but preliminary audits indicate that all cases were handled and directed in accordance with the requirements and criteria set out on the procedural guidance. We would anticipate that the GMC will share its findings with the new body and act upon them appropriately.

12. We have not identified any similar issues in relation to the other regulatory bodies.

13. The creation of the Independent Adjudicator through this Bill will enhance racial equality by the separation of the adjudication function from the case preparation function of the relevant regulatory bodies. This move will address public concerns around the perception of institutional bias. The use of suitably trained and diverse panellists will support this.

Disability and Gender Equality

14. There is no information which indicates that there are concerns regarding disability and gender equality with regard to this policy. However the Tackling Concerns Nationally report recommends that such issues be monitored and we support this.

Age, religion or belief and sexual orientation Equality

15. There is no information which indicates that there are concerns regarding these issues with regard to this policy.

16. The collection of data on this and the other equality strands will be a matter for the bodies concerned and it is anticipated that they will, as a minimum, follow the current general equality duties on public bodies. It is noted that duties in relation to age, religion or belief and sexual orientation are included in the current Single Equality Bill and it is expected that they will form part of the general duties by the time the new body is operational.

Human Rights Impact Assessment

17. The powers proposed are in accordance with the European Convention for Human Rights (and thereby the Human Rights Act 1998). The particular article of relevance is Article 6: The right to a fair trial. Arguably, article 1 property rights might also be affected.

18. The introduction of a new body which is impartial and independent will enhance this as the current system used by regulators does not always allow for such a separation of the investigation, prosecution and adjudication functions.

Rural Proofing

19. The new legislation will not have an impact on rural communities.