Department of Health

Promoting professionalism, reforming regulation

Questionnaire

Response from the Chartered Society of Physiotherapy

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Contents

1. Summary of the questions

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

Response:
We see the logic of a body advising UK governments on which groups of healthcare professionals should be regulated. New arrangements should address the ambiguous way in which some groups are currently put forward for statutory regulation. This lack of clarity on process seems to have arisen since the publication of the Command Paper in 2011, which effectively halted the expansion of further statutory regulation, and in a context of different regulators having different remits for recommending specific groups for statutory regulation. In turn, this seems to have led to some decisions to put forward some groups being overly open to political influence. The consequence of this is that an inconsistent approach is taken to whether and how statutory regulation is either progressed or ruled out for specific groups.

For these reasons, we welcome a different approach being developed. However, we strongly question the appropriateness of the PSA taking on an advisory role in this area, and contest the assertion that this would create no conflict of interest. Given the Authority's current broader remit, attention would need to be given to how the PSA could be enabled to take an objective approach to providing advice to UK governments.

To expand on our points above, enacting its accredited register system creates a conflict of interest for the PSA, with the incentive to channel groups into setting up accredited registers, rather than the PSA making the case for their being subject to statutory regulation. This seems a significant risk when the PSA is able to accredit multiple registers that relate to the same area of practice; the PSA's accreditation of registers forms an income stream for itself; and the PSA actively promotes (to employers and others) the value and currency of its accredited registers.

We also challenge whether it would be appropriate for the PSA both to define the criteria against which groups would be considered for statutory regulation (plus see our response to question 2) and apply these criteria in recommending to UK governments which groups should be regulated in this way.

Careful consideration must therefore be given to how an advisory role to UK governments could be set up in order to ensure that the body conferred the role could enact it with due impartiality and independence.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

Response:
We agree that there is a need for greater consistency and rigour in how decisions are made about the appropriate level of regulatory oversight required for different professional groups. As proposed, this needs to include the development and application of criteria.

We see the need for the criteria put forward by the PSA require development. However, additional elements and dimensions need to be included to ensure the criteria could enable a full and accurate appraisal of risk. These additional elements include consideration of the following:

- Whether practitioners are responsible and accountable for their decisions, actions and omissions, rather than their undertaking activity delegated by other (regulated) practitioners; if a group is not autonomous and has their practice overseen by others, this may be a key factor in determining that they do not need to be subject to statutory regulation (since the parameters of such regulation would be very limited)
- How a group is typically employed to deliver a service (in addition to the patient/client groups to whom they deliver a service and the environment(s) in which they do this); a group that is either wholly or primarily self-employed, or that tends to fulfil more than one type of employment contract at any one time, may present more of a risk than a group that is wholly or mostly employed and in relatively 'standard' and stable ways and that are more obviously subject to local clinical governance processes
- The diversity of a group's practice (in addition to its complexity and management of uncertainty and risk), in terms of its scope, the range and nature of patient/client groups to whom practitioners deliver a service, and the environments in which they typically practice may all present a greater risk than if a group's practice is relatively uniform across each of these areas
- Whether practitioners already need to be subject to statutory regulation to fulfil their particular role; the recent consultation on medical associate roles raised the prospect of advanced critical care practitioners being subject to separate regulation, while making the recommendation (which we supported) that their existing pre-requisite of being a registered healthcare professional did not substantiate the case for separate, additional regulation - however, we understand some other organisations, including regulators, made the case for the practitioners' separate regulation; the issues raised by this scenario require fundamental consideration, including by reviewing the ongoing currency of the recommendations made by the PSA's predecessor organisation (the Council for Healthcare Regulatory Excellence) in 2009 in this area
- The extent to which a group's scope of practice is distinct from that of other groups and professions, including those that are already subject to statutory regulation; if their scope of practice is not sufficiently distinct, they may still need to be subsumed within existing regulatory arrangements if the risk they present fulfils other criteria
- The extent to which a group's scope of practice and activity is likely to evolve, particularly in the context of changing population/patient, service delivery and workforce needs; a group that offers the potential to deliver services differently and the nature of whose practice is likely to change in response to changing needs may present greater risk than a group for whom activity is projected to be stable and relatively fixed.

To support implementation, the following would also be essential:

- A shared and informed understanding would need to be developed of the complete set of criteria against which groups/professions would be considered - this includes what the criteria are intended to mean (and not intended to mean), and how they can be applied consistently to different professional groups
- Those making recommendations and decisions would need a sound understanding of the nature of the scope of practice of different groups and professions; the consultation document itself seems to make certain assumptions about the range of professions currently regulated that are not necessarily informed by a well-rounded understanding of the breadth of current activity and roles within healthcare.

The above is essential because there is the scope for very different assumptions and interpretations of the nature of the risk presented by different professional groups and activity to be brought to decision-making. The nature of different groups' role and activity may not to be

sufficiently or widely understood. This in turn presents potential risks to decisions being made that uphold the public interest and patient safety.

For the reasons identified in our response to question 1, it is essential to review whether the PSA could be sufficiently objective in developing and applying criteria to assess the appropriate level of regulatory oversight for each professional group.

It would also be essential to review whether the PSA should be required to apply the same criteria to determine whether it is necessary for itself to maintain accredited registers for specific groups (recognising that the criteria applied to accredited registers would be at a lower threshold level than for statutory regulation). Currently organisations simply choose whether to put themselves forward for this purpose, including as a way of increasing the profile of the practitioners that they represent. It is possible that priority areas are not necessarily being attended to or addressed through the accredited register arrangements.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

Response:
In line with using criteria to determine the level of regulatory oversight required for different professional groups, it seems logical that the professions already subject to statutory regulation are appraised against these. However, in line with our response to question 2, it is essential that

- The criteria are fully developed
- The criteria are applied consistently
- The criteria are applied with an underpinning, thorough understanding of the nature of the scope of practice, activity and roles of different professional groups (both those currently within and outside statutory regulation); this includes their practice environment, parameters of practice, identified areas of potential risk, and projected areas of development.

Otherwise, there is the danger that misinformed, inconsistent and potentially short-term judgements would be made about the appropriate level of regulatory oversight required for each. This then runs the risk that decisions would require subsequent review and potentially need to be over-turned. More significantly, it could result in poor decisions being made and the public interest and patient safety being put in jeopardy.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

Response:
We strongly question the use of prohibition orders as a concurrent, alternative to statutory regulation for some groups. This is for the following reasons:

- There is a risk of creating confusion (for the public, patients, employers and professional groups) through the use of two different models; i.e. the use of registers positively to affirm individuals' right to practise a particular profession, and the parallel, negative use of a different type of register to denote that individuals are *not* fit to practise
- The more fundamental issue that statutory regulation is predicated on regulation by profession, rather than by activity; however, the principles set out for the use of prohibition orders seem to mean that individuals, if included on a negative register, would not be able to practise particular types of activity, rather than a profession or occupation

- This seems to create a further ambiguity about whether it is planned that prohibition orders would be used to delimit the activity of professionals subject to statutory regulation (e.g. as an outcome of a fitness to practise case), or only as a measure for those who sit outside statutory regulation.

Q5: Do you agree that there should be fewer regulatory bodies?

Response:
We agree that there is a logic to reviewing the current number and configuration of regulatory bodies. However, such a review must be predicated on appraising the most effective and efficient ways in which statutory regulation can be exercised to protect the public and ensure patient safety. The assumption needs to be avoided that larger regulators are necessarily more effective and efficient than smaller ones (beyond simple economies of scale). Starting a review by asking whether there are too many regulatory bodies is overly simplistic and superficially focused on issues of cost. However, it may be the conclusion that is reached.

It is essential, therefore, to define criteria against which the current configuration and number of regulatory bodies can be appraised. These could logically relate to

- The effectiveness of respective current regulators in fulfilling their shared, primary functions and what can be inferred as significant in this comparison in terms of their size and configuration (i.e. as a single-, or multi-profession regulator)
- The efficiency of respective current regulators in fulfilling their shared, primary functions and what can be inferred as being significant in this comparison in terms of their size and configuration (this analysis would obviously need to compare the registration fee charged by each regulator, and how much the size of a regulator is inversely proportionate to its level of registration fee)
- Whether conclusions can be reached about a single body having statutory oversight of a minimum/maximum number of registrants and/or a minimum/maximum number of professions, and how far the diversity of the professions plays a role in this.

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

Response:
We broadly set out the advantages and disadvantages of fewer regulators below.

Advantages

- Greater consistency in how regulatory requirements are expressed and exercised, thereby achieving greater clarity for the public, patients, employers and the professions/professionals subject to the requirements
- Economies of scale for enacting regulatory functions (i.e. less duplication of effort, time and money on the same, shared areas of activity)
- Promotion of expectations around inter-professional practice in response to public and patient needs.

Disadvantages

- Potential dilution of the effectiveness and efficiency of regulatory processes if standards and processes are not developed and implemented with sufficient understanding of the distinct nature of the professions under a particular regulator
- Potential for individual regulators to take on responsibility for a diffuse range of professions for pragmatic, perverse reasons (e.g. if there was a move to ‘shoehorn’ all regulated

professions into a predetermined number of regulators), rather than decisions being made on which configurations would be most effective and efficient
- Potential for single regulators to take on responsibility for professions of very different sizes, risking disproportionate attention being paid to different groups and how they are regulated.

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

Response:
In line with our response to question 5, there is the scope to review and more logically configure the current regulators, with the likely effect of reducing the overall number. This review would need to involve a focus on the following:
- A review of the model that the HCPC represents, with consideration given to whether and how this successful multi-professional model could appropriately be replicated; this should include consideration of the maximum number and diversity of professions under a single regulator to safeguard effectiveness, efficacy and efficiency
- The logic of any one regulator only having responsibility for one profession, particularly if that profession is small in terms of its number of registrants (while appraising the benefits that arise from single-profession, small regulators, including in terms of their effectiveness and efficiency)
- A fuller review of the current costs of/fees charged by individual regulators in order to fulfil their statutory regulation function, with exploration of how these could be reduced through a smaller number of regulators with responsibility for 'cognate' professions (i.e. in logical clusters), while also maintaining or enhancing their effectiveness and efficacy.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

Response:
Yes. All regulatory bodies should hold the same range of powers to resolve fitness to practise cases. Without this equity, there is the risk that all parties involved in fitness to practise proceedings (including the healthcare professionals who are subject to them) are not treated in a consistent, equitable way. There is also the risk that different ranges of powers creates confusion and inequity for all parties, including the public, complainants, bodies that represent complainants (including trade unions), and employers.

Creating this equity in the range of powers held should be factored into a broader review of the number and configuration of regulators.

Q9: What are your views on the role of mediation in the fitness to practise process?

Response:
It seems logical to enable mediation to be used in the fitness to practise process where this is appropriate and proportionate to the issues concerned and upholds the public interest and patient safety.

We support the broader proposals that the model of fitness to practise should be an inquisitorial, rather than an adversarial, one, with an emphasis that issues are fully pursued and issues resolved in ways that are most constructive for upholding the public interest and for delivering and sustaining safe, high-quality patient care.

To inform how mediation should be progressed and used in revised models of regulation, it would be important to review how it is used currently by existing regulators and what can be inferred from and about variation in their use of it and its outcomes.

Q10: Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance?

Response:
No. We agree that fitness to practise performance should not form an undue emphasis in how the performance of regulators is measured. However, given the significance of how fitness to practise cases are managed to fulfil the regulators' public interest and patient safety role, it is essential that performance in this area is a key focus, with appropriate action taken to address and mitigate poor performance (however this is manifested).

In line with the above, regulators' performance must be kept under review against a set of common standards. The standards need to relate to adherence to process and timescale, as well as the quality of outcome in terms of the decisions made. This is needed to ensure that the interests of the public, individual complainants, the healthcare professionals who are subject to proceedings, and employers are all safeguarded and upheld.

Monitoring regulators' fitness to practise performance would also need to be developed taking account of the changes made in other areas, including those raised in questions 12 and 20, and in terms of the number and configuration of regulators.

Q11: Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

Response:
Yes. This is as an important safeguard to ensuring that public interests and patient safety are not compromised. It is also necessary to ensure that registrants are demonstrably subject to consistent and fair decisions and that all parties can have confidence in the quality of the decisions made by regulators.

Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

Response:
Yes, but with caveats.

We believe that regulators have a strong role to play in promoting professionalism and averting things going wrong through taking a positive, proactive approach to seeking to ensure that registrants fulfil statutory regulatory requirements. This is fully in line with regulators' role in exercising statutory regulation to protect the public and to minimise risks to patients.

While being inherently in the public interest, enacting this role also fits with reducing the human and financial cost of regulation and recognises that regulators exercising their fitness to practise role represents a significant amount - and in some cases the majority - of current bodies' expenditure. Activity that reduces the incidence of things going wrong, averts patient harm, and reduces the financial and human cost of fitness to practise proceedings can only be positive.

However, there is an important distinction to be made between regulators' role in promoting professionalism and registrants' engagement in regulatory requirements, and regulators supporting registrants to meet and retain professional standards, as couched in the question.

This is for the following reasons:

- Other bodies, including professional bodies and membership organisations, play a significant and strong role in setting professional standards and in promoting and supporting the fulfilment of these; this includes within initial education and career-long professional development (also see our response to question 20)
- Professional bodies' activity in these areas includes a strong focus on person-centred professionalism, scope of practice, developing practice and service delivery to respond to changing population and patient needs, and developing and applying the evidence base relating to professional practice and service delivery - all with an increasing emphasis on collaborative activity to encourage, support and enable inter-professional and inter-agency approaches in all these areas
- Regulators are not currently set up or resourced to undertake activity in the above areas; if they were to move to supporting registrants to meet and retain professional standards in this way, it would form a significant shift in their purpose and role, and would raise questions about how they were funded, and how they deployed their resources
- This would create unhelpful duplication with the role of other organisations, including professional bodies and member organisations
- In turn, this would create ambiguity in regulators' role and function, and potentially a diminution of regulators' public protection and patient safety roles.

We work in parallel with the HCPC, and to support the processes it enacts. We recognise that how we work as a professional body with this regulator may be significantly different from how other current regulators work with professional bodies. This in part may reflect the distinctive multi-professional nature of the HCPC's regulatory role, and the particular ways in which the roles and activities of professional bodies across the allied health professions (AHPs) have developed and matured over a significant period.

Positive features of our role in relation to the HCPC include the following:

- We provide profession-specific curriculum guidance for the HCPC to use in implementing its generic education standards and approval role
- We exercise a quality assurance and enhancement (QAE) role in parallel with the HCPC's education approval role; in this, we focus strongly on how physiotherapy students need to be prepared for their future professional practice, taking account of changing population/patient, service delivery and workforce needs
- We exercise a peer review approach, enabling an in-depth critique of programmes' education design and delivery and strategic positioning (in the context of changing needs); this strongly supplements the HCPC's consideration of education provision against its regulatory requirements
- Our role significantly adds to the education approval role of the HCPC, contributing to assurance that education provision is fulfilling needs relating to current and future patient care, service delivery, professional practice and workforce requirements, and that there are the resources to sustain and ensure the quality of programmes' delivery and development; this includes education providers' human and physical resources, inter-professional approach, research activity, links with service providers, and access to sufficient practice-based learning capacity
- In line with all the above, we play an important role in supporting the sharing of good practice in education, encouraging and enabling a 'community of practice' to sustain

physiotherapy education's ongoing development, quality and currency - this is central to our role as a professional body, and both distinct and complementary to the education approval role of the HCPC
- We have a long-established outcomes-based approach to continuing professional development (CPD), and have provided significant support to how the HCPC's CPD requirements have been defined and how they are exercised.

We would expect the elements outlined above to be factored in to any review of regulators' education approval role. In particular, consideration must be given not just to the current role of the professional regulators and that of higher education regulators. Rather, strong recognition must be given to professional bodies' significant role for some healthcare professions.

We would also expect the following to be considered in any review:
- There could be distinct risks attached only to considering the outcomes of education programmes within regulators' education approval processes, when how learners are prepared for their future professional practice also has strong significance; this is particularly the case in a context of increasing diversity in programme provision and the environments in which education provision is delivered
- The role of professional regulators cannot be considered in isolation
- How professional regulators' education approval role is supported and informed by other bodies' activities, resources and processes (particularly those of professional bodies) should not be under-estimated, and needs to be fully understood
- The very different approaches that current regulators take to their education approval role needs to be better understood and requires careful evaluation (including in terms of its impact and value)
- It should not be assumed that an approach to considering individuals for their eligibility for registration, as we understand the GMC is beginning to pilot (rather than this in large part being managed through the education approval role), would be a more time-efficient or necessarily more effective approach.

Q13: Do you agree that the regulators should work more closely together? Why?

Response:
Yes. We see it as essential that the regulators work more closely with one another than they do currently. This is for the following reasons:
- The standards and processes that each regulator works to, develops and implements need to have clearer commonality and equivalence
- The central tenets and requirements of statutory regulation need to be clearer and brought to the fore in equivalent ways by regulators (with a transparent explanation of due difference)
- The value and scope for more joint working and the sharing of learning and best practice between regulators needs to be identified and acted upon, including so that the outputs are of a better quality and that the activity to produce them is more efficient
- It needs to be easier for the public, patients, employers and for the professions and professionals subject to regulation to understand the standards and processes of each regulator; this includes through being able to access a joint register
- Different stakeholders (including the public, patients, employers and education providers) need to have confidence that they would receive an equivalent response from each regulator (rather than there being the potential for this to be significantly different)
- Unnecessary duplication of effort needs to be avoided, and the most efficient use of resources achieved.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

Response:
We support the areas suggested for how the regulators should be encouraged (and in some cases required) to undertake more joint activity. This is the reasons we have set out in our response to question 13.

We also think the following areas should be explored:

- How regulators would have a shared responsibility for raising ideas for potential joint working and/or for consideration by the PSA
- How regulators would have a shared responsibility to identify where and why they have different requirements or approaches and to review whether these are justified
- How regulators (particularly following any reconfiguration that led to a greater number of bodies with responsibility for a range of professional groups) would have a shared responsibility to identify and pursue issues raised about addressing issues in significant depth.

To clarify, the HCPC only has a very small number of profession-specific standards of proficiency, with the bulk of its standards, of all types, being generic in nature. As highlighted in our response to question 13, much of the required professional specificity is supplied by the relevant and appropriate input of individual professional bodies. The importance of this should not be under-estimated in appraising how the multi-profession regulator model is able to work effectively and efficiently.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

Response:
Yes. It is essential that there is appropriate data-sharing between healthcare regulators. This needs to include data-sharing between professional regulators and between professional and systems regulators. The latter is needed as part of addressing the current gap in how the two types of regulators exercise their respective roles in fulfilling public and patient interests.

As part of helping to identify potential harm earlier, appropriate data-sharing between regulators can enable insight into and understanding of factors that may signal the risk of potential harm. It can therefore avert potential risks to patient safety and help to identify and address the sources of risk.

In particular, we see this as essential for identifying whether concerns of an organisational nature that are identified by a systems regulator form significant contextual factors in relation to the regulation of individual healthcare professionals. Issues relating to an organisational culture may work against professional engagement and/or raise more significant concerns about the well-being, practice or conduct of individual healthcare professionals. Similarly, an issue that may be raised with a professional regulator about an individual's possible conduct or fitness to practice may signal organisational issues that need to be addressed by a systems regulator.

Without this stronger integration of intelligence gained by different regulators and of different types, there is the potential for risk factors not to be identified and appropriately acted on,

learning not to be derived and applied, and key recommendations from the 2013 Francis report and other inquiries not to be implemented.

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

Response:
In part. Giving regulatory bodies greater flexibility to set their own operating procedures has a logic, and should enable efficient working. At the same time, it is essential that all regulators are required to adhere to a set of common principles, such that all parties - including the public, patients, employers and the professions/professionals subject to regulation - can be confident that there is parity in how each body enacts its key functions.

Confidence in this parity is important from an efficiency and cost perspective. It also links to ensuring confidence that similar issues are managed consistently, fairly and equitably by each regulator. This includes in terms of regulators' responsiveness to issues of concern being raised, their supply of information, and their timely and effective management and enactment of their processes and the outcomes of these.

We believe that it is particularly important that consideration is given to the level of consistency achieved in regulators' approach to the data that they each gather, interpret and make available (including through published reports). Currently, regulators operate in very different ways in this area, sharing information and their analyses and interpretations in very different ways from one another.

We recognise that this is partly to do with structural differences in the regulated professions. For example, the GMC is able to gather and make available far more data about the progression of medical registrants than other regulators are able to do, given the particular links between doctors' registration status and their progression through structured postgraduate medical education and training. However, as an example, there is a distinct difference between the types of data and analysis that the GMC proactively shares, and the types of data and analysis that the HCPC makes available, with the latter only relaying information relating to workforce profile in response to freedom of information requests.

This current difference of approach has a significant impact on how each regulator engages in and contributes to key strategic issues relating to the delivery of care to patients and how they advise government departments and arms' length bodies. At times such as now (in the context of an increasing recognition of a need to review how care is delivered across the health and care system and by whom), this has increasing significance.

Bluntly, the different approach of different regulators means that some directly engage in political and policy debate and overtly act in an advocacy role for the profession or professions they regulate, while others do not. It seems essential that points of principle are defined to ensure that all aspects of regulators' operating procedures are equitable, and so that the impact of current difference is moderated.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

Response:
It is essential that the accountability of regulators is reviewed in the context of devolution having progressed since bodies' accountability was defined in legislation. A review should be undertaken as to how this accountability can most appropriately be articulated.

The aim should be ensure the following:

- A consistent approach for all regulators (and as an outcome of whatever reconfiguration of the number and remit of regulators is progressed)
- Clarity in how the accountability at UK and country level is enacted and implemented.

As part of this exercise, careful exploration would need to be undertaken of how different expectations of the regulators (whether in terms of how they materially enact their role, or how they report on it) by different governments would be managed.

Consideration would need to be given to how strengthened accountability could be achieved, while guarding against the potential for professions currently subject to UK-wide regulation to become subject to country-specific regulation. This could have implications for their scope of practice, mobility and responsiveness to workforce needs, and how their professionalism, professional engagement and fulfilment of regulatory standards is supported by professional bodies and other UK-wide organisations.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

Response:
We strongly question whether moving to regulatory councils comprising a mix of non-executive and executive members would ensure stronger governance. In particular, this is a model that runs the risk of the executive of each regulator becoming accountable to itself.

We see it as essential that the councils of regulatory bodies are reviewed to ensure that they adhere to a common set of principles and that these principles provide assurance of adherence to sound governance and decision-making. This needs to be done in ways that align with any progression of a different number and configuration of regulatory bodies and any re-definition of how regulators need to enact their roles.

A change in the composition of the councils also needs to be strongly informed by evidence and learning about what works most effectively in the performance of governing bodies, particularly in the fulfilment of public body roles, the standards required for public appointments, and ensuring appropriate checks and balances in how sound decisions are made.

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

Response:
No. We are unsure about the purpose this would serve. We are also concerned that places being reserved on a board for employer representation would be out of kilter with a criterion-based appointment process, and could distort the nature of the oversight role of a regulatory body council. For example, such distortion could arise if pre-eminence were given to the

interests and concerns of a particular employment sector (for example, this could lead to issues of costs to employers inappropriately being factored into the decisions made by the council of a regulatory body).

We believe that it would be useful to review how employers can be enabled to develop a greater understanding of the nature of professional regulation and the links and inter-dependencies between professional and systems regulators and the latter's regulatory requirements and processes.

As examples, it is important to raise employers' understanding of and engagement with the following:

- Their responsibility to fulfil systems regulators' requirements for ensuring that staff are prepared and supported to enact the roles for which they are employed (including to ensure patient safety)
- Their responsibility to support individual member of staff's compliance with professional regulators' standards (including in terms of sustaining and demonstrate their fitness for practice and purpose)
- When recourse to a professional regulator's fitness to practise processes is appropriate; i.e. compared to when employer action would be appropriate and proportionate (as highlighted in a report recently published by the HCPC on fitness to practise cases relating to social workers and paramedics).

We would see all the above as needing to be progressed through strengthening links between professional and systems regulators (see our response to question 15) and professional regulators strengthening their engagement of employers. This would need to be done in ways other than employer views being reflected on the councils of regulatory bodies.

Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

Response:
We question how this question is framed. It is central to regulatory bodies' role and fulfilment of purpose that they focus on ensuring that individuals who they admit into registration and enable to maintain registration demonstrate their fitness to do so. In this context, we wish to make the following qualifying statements:

- It is misplaced to imply that regulatory bodies either "produce" or actively "sustain" registrants who are fit for practice and purpose; rather, regulators define the standards required for admission and for remaining on a register and of which they require individuals to demonstrate their adherence and fulfilment
- Regulators have an underpinning role in promoting understanding of what fulfilment of regulatory requirements means for individuals' professionalism and professional engagement; however, this is not the same as 'producing' or 'sustaining' registrants' fitness to practise
- As a professional body, we would expect to continue to work with the regulator with which our members are registered to ensure both that we inform how the body promotes understanding of its requirements and that our own broad range of activity relating to our members' professionalism and professional engagement continues to support their fulfilment of regulatory requirements
- The value and impact of current regulators' different approaches to ensuring registrants remain fit to remain on the register need to be evaluated, recognising that these are underpinned by different principles and approaches, and make different types of demand on

registrants; e.g. some are more strongly outcomes-based and overtly focused on how registrants' learning and development informs and supports their service delivery and patient care, while others are more strongly focused on issues of input and process, and therefore more prescriptive in their requirements
- In line with the above, it should not be assumed that some regulators' enactment of revalidation requirements is necessarily more robust than others' enactment of CPD requirements; the particular value and impact of each for sustaining and demonstrating registrants' fitness to practise needs to be evaluated
- Particular consideration needs to be given to how regulators consistently articulate their approach to the development of registrants' professional activity, in terms of both the scope and level of their practice over a career - this is essential in a context of fast-moving developments in workforce requirements and job roles and with an increasing focus on ensuring that healthcare professionals are flexible and adaptive
- In addressing this imperative, care needs to be taken to safeguard patient safety while avoiding an approach that is overly restrictive and bureaucratic and that works against workforce flexibility
- As an example, if a requirement were introduced that registered healthcare professionals had to secure additional registration to act in an advanced practice role (as mooted, if not recommended, in the recent medical associates consultation), this would unhelpfully require individual professionals to hold different forms of registration to practise and potentially to be subject to the requirements of more than regulator
- Issues relating to the regulation of healthcare professionals in the context of workforce, job role and advance practice developments as requiring particular and careful consideration; we would expect to be strongly involved in this exercise
- As part of the above, consideration needs to be given to the current variation in whether registrants of different regulators have protection of title; the value of conferring this protection needs to be appraised, both to ensure public protection and patient safety and to achieve greater clarity of professional role through regulation.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

Response:
We are concerned that the primary motivation of the proposals contained in the consultation is to reduce the cost of regulation, rather than to strengthen its quality. We would wish to be assured that any progression of changes to professional regulation that are progressed as an outcome of the consultation were predicated on enhancing professional regulation and not just to reducing its burden and cost. At the same time, we recognise the importance of ensuring that any changes could be enacted efficiently, rather than adding to the burden and cost of regulation.

We believe that any potential savings generated through reforms should lead to a reduction in fees for registrants and to ensure that fees remain at a fair, proportionate level.

Any developments in regulators' roles (including any expansion of activity to strengthen their support for professionalism) should be fully costed. This is in addition to their rationale, purpose and likely value and impact being fully appraised. Full consultation would need to be undertaken as to whether proposed activity would fit with regulators' public protection and patient safety role and taking account of the established roles and activities of other types of organisation (see our response to questions 12 and 20).

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?
- an increase
- a decrease
- stay the same

Please explain your answer and provide an estimate of impact if possible.

Response:
The impact on our organisation would depend on whether and how the possibilities raised in this consultation are progressed. However, to rehearse a few possibilities, we would anticipate the following:

- We would expect to have a strong input to appraisals of risks attached to professional activity; this would affect how we use our capacity in the short-term and therefore how we judge we need to use our available resources (this would not necessarily generate an increase in costs, but would affect how we deploy our capacity and therefore would imply a reduction of our activity in other areas)
- If changes were made to fitness to practise processes (and particularly a move away from an adversarial model) and fewer complaints were progressed through full proceedings, this should decrease costs attached to fulfilling our member representation role
- If the outcome of a review of regulators' education approval role was a reduction of bodies' activity in this area, this would be likely to increase our workload and the significance of our role in this area; it would therefore lead to an increase in the costs that we incur
- If regulators were to increase their role in supporting registrants' fulfilment of professional standards, this could have a direct, delimiting impact on our role and therefore potentially reduce the reasons why individuals join us as a member organisation; if the case, this would have a direct impact on our income
- If there were to a be shift or change in how our members' continuing fitness to practise were monitored, this would be likely to increase how we support our members in this area and therefore increase our costs.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

Response:
We have identified a number of ways in our response to other consultation questions how changes could be made that should contribute to improving public protection and patient safety. These particularly relate to increasing the consistency and transparency with which different groups and professions are subject to statutory regulation, how a reconfigured number of regulators enact their roles, and achieving a greater commonality of standards and requirements against which they do this.

At the same time, we wish to emphasise the following qualifying points:

- A key criterion for any changes to professional regulation must be that they contribute to improved public protection and patient safety
- A further criterion should be that, in addition to improving public protection and patient safety, any changes do not intentionally or inadvertently compromise the interests of other key stakeholders
- In a number of our responses to questions we have included caveats to our support for change; these relate to needing more developed principles and criteria to inform how regulatory change is enacted, ensuring due clarity about the nature of professional

regulators' roles (including in relation to other organisations' roles, including those of professional bodies), and the importance of achieving stronger links between professional and systems regulators

- Specific areas in which change should only be progressed subject to more in-depth work include how decisions are made about which groups should be regulated, the configuration and number of regulators, and achieving clarity on the appropriate nature of regulators' roles in promoting and assuring registrants' professionalism.

Q24: Do you think that any of the proposals would help achieve any of the following aims:
- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?
- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?
- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?

If yes, could the proposals be changed so that they are more effective?

Response:
It is difficult to comment on the impact of the proposals as couched in the consultation, given it is unknown what will be progressed, or how this will be done. We would expect the development and progression of any developed proposals arising from the outcome of the consultation (e.g. a reduction in the number of regulators and the remaining ones being reconfigured) to be subject to an equality impact assessment. We would also expect the details of any changes to be subject to such an assessment prior to implementation and for their impact to be kept under review from an equality and diversity perspective.

If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

Response:
Please see our comment above.