UK Healthcare Professional Regulatory Reform Team
Professional Regulation
Department of Health
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By e-mail to: reformingregulation@dh.gsi.gov.uk

Date: 23 January 2018

Dear Sir,

Re: Consultation "Promoting Professionalism, Reforming Regulation". The response from the Academy for Healthcare Science

AHCS and its officers welcome the opportunity to contribute to this consultation.

What is the Academy for Healthcare Science?

The Academy (AHCS) is the single overarching body for the entire Healthcare Science workforce in the UK and works alongside the specialist professional bodies to speak with one clear voice for Healthcare Science. It was also set up explicitly to deliver The Certificate of Attainment & Certificate of Equivalence for the NHS Scientist Training Programme (STP), Equivalence and Registers for those groups outside statutory regulation. We now also deliver NHS (Healthcare Scientist) Practitioner Training Programme (PTP) and Higher Specialist Scientist Training (HSST).

The AHCS was established as a joint initiative of the UK Health Departments and the professional bodies across Healthcare Science. The AHCS was commissioned to undertake and support key projects including:

- Developing consistent regulation for the Healthcare Science workforce e.g. by establishing accredited voluntary registers where none exist.
- Implementing a system to assess and confer 'equivalence' of the existing qualifications and experience individuals have, mapped to the outcomes of formalised quality assured training programmes.
- Quality assuring education and training in partnership with other stakeholders.
- Developing common standards for Healthcare Science practise.

Context of this response

AHCS has responses to this consultation from three perspectives:

1. As an organisation holding and having responsibility for a PSA accredited voluntary register with several Parts, and all the related duties to protect the public and service users from those registered.

Setting national standards and the assessment for relevant healthcare science applicants for eligibility to apply for entry to the relevant part of the statutory HCPC Register;
2. As the "One Voice" on behalf of professional bodies for the healthcare science professions;
3. As a not-for-profit company supporting healthcare science.

AHCS responses to the specific 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?

- Yes;
- Regulation should be uniform across the 4 countries of UK;
- Support of and confidence in PSA as an independent body overseeing regulators and providing advice.

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?

- Agree;
- However, within any one professional group there will be a range of "scores" against the proposed 2 stage risk assessment. Thus assessment of a professional group will only ever be an average and itself arbitrary;
- Developments in medical technology and service delivery models will mean that risk-based assessments at professional group level will rapidly become out of date;
- The approach does not take account of the need to accommodate new professions and new roles which cross traditional professional boundaries.

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?

- We agree that the current statutorily regulated professions has arisen more by historical accident than by design and is due for review;
- The current system is complex for the public to understand which regulator they should refer an issue to;
- The Francis Report regarding the failures in Mid Staffs cited a wide range of staff and cultures contributing to inadequate healthcare delivery. We therefore consider that regulated professions must include all with influence and impact, not only those in direct patient facing professions;
- We are attracted by the PSA proposal in "Regulation Rethought" reproduced in Table 2 of the consultation for all those having impact on patients and patient services (essentially everyone) to apply common standards with occupation specific standards only where necessary. We believe such a generic approach would dramatically simplify the administration and practice of regulation with reduction in costs for all;
- As a priority we suggest review of areas where there are multiple or closely overlapping regulators, e.g. Pharmacy and "Talking therapy" professions.

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

- We recognise the weakness of sanctions where registration is non-statutory that the prohibition order attempts to resolve. However we believe this will involve administrative complexity. A much better, simpler solution likely to be better understood by the public and users of services, is for regulation to be at a uniform level for all including the ultimate sanction of "struck off" preventing practice.

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

- Yes;
- We are in broad agreement with the proposals of the Law Commission in their 2014 report;
- However we believe a more radical model is required rather than simply reducing (i.e. merging together) existing regulatory bodies.

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

- We agree with all the rationales expressed in paragraphs 2.12 & 2.14 of the consultation document. In particular we recognise the advantages of economy of scale and removing unnecessary variation;
- We note that, at least in the recent past, some regulatory bodies have been perceived by the public as protecting professions and professionals more than the public and service delivery standards. We do not have information regarding whether such perceptions have changed. Such perceptions undermine the whole concept of regulation balancing powers of professionals and those served. Fewer regulators with more explicit generic behavioural standards might help increase public confidence;
- In the minds of many professionals registration in their profession is a privilege jealously protected and the regulator is seen as almost defining the profession. Therefore a simple reduction in the number of regulators is likely to be met with considerable professional resistance;
- There may also be genuine differences between professions / occupations that require special consideration, for example those professions serving particularly vulnerable groups such as children with mental illness.

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

- We believe there is significant benefit from restructuring to between one and three regulators;
- Due to its very large size there is an argument for leaving NMC (and possibly GMC) as separate bodies but with standards and procedures consistent with other regulators;
- For all others we suggest a model based on that currently in place in HCPC – of a generic overarching regulatory body covering all groups involved in healthcare with a register divided into “parts” accommodating the necessary diversity of professions / occupations;
- The overarching regulator would provide scale and consistency across all groups with the occupation / function specific parts maintaining professional identity and necessary diversity under the common umbrella.

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

- Yes;
- Behind our agreement is an implied need for public / complainant education in the objectives of FtP processes. In complainant perception thinking may be dominated by notions of justice “for what they did to me” and FtP primarily as punitive;
- Communication and (if desired) involvement of the complainant is key.

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

- Mediation has some potential in particular cases. We are aware of limited experience by HCPC in the use of mediation;
- However we believe the issue begs further research into the effects and impact. Such research would be a role for PSA or similar overarching body. We suggest there may be lessons from regulated professions outside of healthcare;

- Mediation clearly requires two partners and needs to be done with care. Its appropriateness will be case-specific and depends as much on the complainant as the practitioner;
- There will remain the question of who carries the costs.

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

- Ideally yes;
- But we recognise that FtP will remain a high-impact activity (for both sanctioned registrants and complainants) hence, to maintain public confidence it will remain PSA's major focus.

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?

- Yes.

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?

- Most definitely;
- We agree with the roles in this regard detailed in the consultation document;
- We would add into the list of "supporting professionalism" and continued fitness to practise issues the matter of practice development and innovation in a way that is scientifically rigorous and takes into account the best interests patients in general and subjects participating in research;
- We support the notion of "revalidation" being extended across all regulators however this activity must be appropriately funded.

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

- Yes. We support the notions expressed in paragraphs 4.10 & 4.11of an expectation of regulators working together;
- We believe that the benefits of scale from joint working should not be restricted to statutory regulators but that those PSA accredited bodies running voluntary registers should also be able to "sign in" providing they meet necessary minimum standards administered by PSA;
- We note that the costs of regulation are met mostly by registrants. We see little justification for wide variation in costs, particularly covering core functions;
- We believe that the notion of an "Health Professions Adjudicator" merits revisiting, both in the interests of efficiency but also of transparency and clarity for the public.

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

- We can appreciate some of the points made in paragraphs 4.12 to 4.14 particularly in uncovering systemic problems that lie with employers / service providers which are manifest as professional regulatory issues;
- However we believe that case for explicit data sharing beyond that which is already in the public domain still needs to be justified.

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

- Increased autonomy of regulatory bodies undermines the objectives of efficiency, economy of scale, simplicity of processes and equity of treatment of both affected patients and registered professionals;
- Under an overarching umbrella autonomy is restricted to the appropriate, justifiable unique features of regulated professional group.

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?

- We agree that the devolved administrations need the appropriate powers to hold regulators accountable for activities within their jurisdictions;
- However any variations across the countries will undermine efficiency and equity and would need to be justified by unique expressed needs of the population under the specific administration.

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?

- Yes.

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?

- Employers / service providers are clearly key stakeholders and their views are an important source of insight;
- However the interests of employers may not be the same as the primary roles of regulation. These should always take precedence;
- Ideally the parties will be able to work in partnership in the best interests of the public and patients however the regulatory bodies must remain transparently independent of employers.

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?

- We would regard this as simply part of the regular “business as usual” activity of all regulators;
- However we note that under the current system changes required by different ways of working or new professional roles (especially those crossing traditional professional boundaries) can be very slow to put into effect;
- Should a new structure be established, e.g., along the lines suggested by us in response to Q7 then this would need to be its first action.

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?

- We agree that supporting professionalism is a part of good regulation and therefore reinvestment of part of savings is reasonable;
- We would also wish to see fees controlled with increases to registrants no higher than inflation;
- It would be reasonable for some savings to be directed to ensuring the long-term financial sustainability of regulatory bodies.

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.

- We would envisage an analysis of cost implications to be part of the sequelae following your government response and assessment of actions from this consultation.

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

- A simpler system with common standards applied across the population of healthcare professionals and uniformity of application of those standards will foster the comprehension and trust of the public;
- Hopefully this will dispel the enduring suspicion in the minds of some of the public that regulators are there primarily to protect the interests of professions and practitioners rather than foster best practice;
- Other than the number of complaint and fitness to practise cases raised we do not at this time have any suggestions of how improved pubic protection could be measured. Further research in this aspect of regulation is required.

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?

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?

- Discrimination etc. have been matters that could bring FtP cases for some years. We are not aware of any evidence that such matters have been improved through professional regulation;
- We believe however that these behavioural issues should remain as part of the generic standards of all staff involved in healthcare;
- The proposals will make appropriate regulation easier to administer.

Members of the AHCS would be please to clarify any of the issues we have mentioned above. If required please contact us via: admin@ahcs.ac.uk

On behalf of the component roles of AHCS:

J Stevens, Chair, AHCS Board
P Le Rolland, Chair, AHCS Regulation Council
B Cooper, President