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of Health

# Promoting professionalism, reforming regulation

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# Foreword

The regulation of healthcare professionals must change in order to protect patients, to support the transformation of our healthcare services and to meet future challenges. It needs to be faster, simpler, better and less costly.

When people access healthcare, they trust that the professionals they encounter are properly trained and qualified, that they will treat them with dignity and respect, and that they will not mistreat or harm them.

Professional regulation is central to the systems of assurance that underpin this trust. The nine regulatory bodies that regulate healthcare professionals across the four countries of the United Kingdom (UK) are the gatekeepers to the professions that they regulate. They set the educational requirements needed to enter a profession and the standards required to practise safely and effectively in each profession. They keep registers of people who meet these standards, are qualified and fit to practise. The regulators also set the standards of conduct, performance and behaviour required of professionals and take action where these standards are not met.

As such, they not only oversee the professionalism of every individual practitioner that they register, but are the guardians of the ethos and culture of each profession as a whole. As the professions adapt to the opportunities and challenges of the economic, demographic, technological and epidemiological changes of the coming decades, it is vital that the professional regulators are able to respond to these changes. They must be able to lead the adaptation of professional standards to the changing realities of ensuring safe, effective and respectful clinical care in a way that is efficient, effective and affordable.

There are approximately 1.5 million people registered to practise in the healthcare professions regulated by statute in the UK. The system we have today is a historical patchwork, periodically mended and amended, with different aspects of the resulting regulatory regime reflecting the particular concerns and constraints of the time they were reformed. As a result there is inconsistency, in both practice and legislation.

While the healthcare regulators are generally effective in protecting the public from serious harm, there has been criticism, not least from the regulators themselves, that the system is slow, expensive, complicated, reactive, overly adversarial and confusing for patients, professionals and employers. This complexity makes it difficult for the regulators to operate as effectively and efficiently as they would wish. It also makes it difficult for patients to know when and how to raise concerns about the care provided by a healthcare professional.

Better and more responsive healthcare professional regulation is a shared ambition for both the regulators and all four UK governments.

The way that healthcare is delivered across the UK is changing. In England the NHS *Five Year Forward View*<sup>1</sup> has set out a blueprint for how to meet the challenges that face the healthcare system as a result of a growing, ageing population and advances in medicine and clinical practice. In Scotland, *A National Clinical Strategy*<sup>2</sup> sets out how clinical services will support sustainable health and social care services. In Northern Ireland, *Health and Wellbeing 2026: Delivering Together*<sup>3</sup> sets out a 10 year vision for transformation of the health and social care system to ensure the best possible outcomes for patients. In Wales the approach to prudent healthcare is aimed at ensuring the delivery of healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the benefit of patients.

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The UK's healthcare workforce needs to change to meet the challenges set out in these plans. Future workforce strategies will focus on the development of innovative health and care roles and ensuring that professionals have the flexibility to work across traditional boundaries. We need a UK-wide system of professional regulation that contributes to the delivery of this ambition and supports the development of high quality professionals. This needs to be complemented by a culture that enables professionals to learn from their experiences, including from their mistakes. All too often professionals encounter a culture of blame rather than learning.

This consultation considers what reforms are needed across the UK healthcare regulatory system in order to support workforce development while maximising public protection in a more efficient way. The four UK governments want to take this opportunity to design a flexible model of professional regulation which secures public trust, fosters professionalism and improved clinical practice, while also being able to adapt swiftly to future developments in health care.

We look forward to hearing the views of patients, the public, employers and professionals, as well as the regulatory bodies, on the direction and proposals contained in this document.

## Executive summary

The UK's model of professional regulation has its roots in a system of self-regulation in which professionals themselves were largely responsible for policing their own conduct, performance and behaviour. This system lacked independence and transparency. Through a series of reforms over recent decades a system of independent regulation, in which both the public and professionals have oversight of regulation, has been put in place. Regulation is now more transparent, the processes of the regulatory bodies are more robust and it is expected there are higher levels of patient, public and professional confidence.

Alongside this, new measures have been put in place to provide assurance of those healthcare practitioners practising in unregulated professions. The Health and Social Care Act 2012<sup>4</sup> established the Professional Standards Authority for Health and Social Care (PSA)'s accreditation scheme for voluntary registers. Designed to complement statutory regulation, the PSA accredits organisations that register health and social care practitioners who are not regulated by law.

Where once regulatory bodies may only have contacted professionals at the point of registration, to collect fees or, rarely, to investigate a complaint, now professionals are in more regular contact with their regulator checking their continuing competence and supporting their professional development. Measures have been introduced through revalidation and other systems to assure continuing fitness to practise. This provides assurance that professionals continue to have the necessary level of competence and demonstrate the right behaviours to deliver high quality care throughout their careers.

However, the regulators continue to be hampered by a legislative framework that is in parts more than 150 years old and with outdated procedures that have not kept pace with changes in the health and social care system.

From the perspective of patients and the public, the current system of regulation can be confusing, inconsistent and slow. People are not always clear which professionals are regulated by which regulatory body or against which standards. Staff working side by side in teams might be accountable to different bodies and working to different sets of standards. Different regulators might impose different sanctions for similar professional failings. Employers have to interact with numerous different professional regulators.

The current model of professional regulation deals with complaints about professionals in a largely reactive way, with a strong emphasis on dealing with concerns about a minority of registrants at the expense of supporting the vast majority. Investigations into allegations made about professionals to their regulators (known as fitness to practise procedures) are lengthy and can be frustrating for patients, registrants and employers. Having such an adversarial fitness to practise system at the centre of the regulatory bodies can affect their outlook and culture and does not support early identification and resolution of concerns. This needs to change.

The emphasis on dealing with concerns about registrants after issues have been raised limits the ability of the regulators to support the professional practice of their registrants before problems occur. Similarly, it can inhibit professionals from taking part in safety investigations because of a fear that information from such processes could lead to a fitness to practise referral.

While fitness to practise must remain a key function for the regulators, giving them powers to handle fitness to practise cases in a proportionate way will allow for a more preventative and supportive approach. This will provide the time and resources for regulators to support the ongoing professional development of all registrants.

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In future we expect the professional regulators to work in partnership with employers and higher education providers to ensure that the recruitment, education and training systems they assure and operate are delivering the right people, that they are teaching the right things (through both the formal and informal curricula) and that behavioural problems identified early in a professional's career are properly addressed.

In taking forward reform of regulation of healthcare professionals, the four UK governments have five objectives. These are to:

- improve the protection of the public from the risk of harm from poor professional practice;
- support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;
- deal with concerns about the performance of professionals in a more proportionate and responsive fashion;
- provide greater support to regulated professionals in delivering high quality care; and
- increase the efficiency of the system.

As part of this, the four UK governments need to examine which professions should be regulated on a statutory footing. The case for regulating some professions such as doctors, nurses, midwives and pharmacists on a statutory basis is clear. For other professions this is less obvious.

There is no clear rationale for the current position of having nine regulatory bodies. Some regulators have a large number of registrants and others have relatively few. Research suggests that efficiencies begin to accrue when a regulatory body has a registrant base of between 100,000 and 200,000<sup>5</sup>. Five of the regulatory bodies are smaller than this, contributing to additional costs of the regulatory system. In order to simplify the system, foster greater consistency and reduce costs, the four UK governments believe there is need for radical change. The four UK governments would be keen to understand what form a system containing a reduced number of regulators (possibly to three or four) might take.

Meeting the challenge of the changing healthcare systems in each of the four UK countries requires a regulatory system that supports the development of new models of care and more flexible professional roles. This means ensuring that regulators are able to respond quickly to changes in the way that healthcare is delivered without having to wait for changes to legislation. Giving the regulatory bodies greater autonomy to innovate, balanced with more effective accountability, will help to deliver this.

Through this consultation the four UK governments want to draw on the knowledge, skills and experience of those working in the sector and those using its services. We are seeking views on the approach and proposals set out in this document. These views will inform decisions on how to reform healthcare professional regulation. In particular we want to:

- design a more responsive model of professional regulation which can swiftly adapt to changing patterns of healthcare, develop new roles and new ways of working without the need for frequent legislative change;
- establish clear criteria to assess which level of professional regulatory oversight is appropriate for different professional groups;
- consider whether the current number and set up of healthcare regulatory bodies is delivering effective and efficient public protection;

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- ensure that regulatory bodies have a consistent and flexible range of powers that allow them to take a prompt and proportionate approach to concerns about an individual's fitness to practise;
- enable regulators, working with professional bodies and others, to better support professionalism among registered groups and to provide assurance on an ongoing basis that practitioners are competent and up to date; and
- increase joint-working, sharing functions and services between the regulators.

# 1. Introduction

1.1. The primary purpose of the regulation of healthcare professionals is to protect patients and the public from harm. Health professionals are regulated in order to ensure that they have the skills, competence, health and attitudes that command public trust and patient confidence. Regulatory bodies:

- keep a register of qualified professionals who are fit to practise so that patients and service users know who is and who is not qualified;
- set the outcomes required from undergraduate (and in some cases postgraduate) education and training that must be met before registration is granted, as well as inspecting education and training providers;
- set the standards of conduct, performance and behaviour expected of a registered professional so that professionals deliver care safely and effectively;
- operate a system to ensure that registered professionals continue to meet those standards, that their knowledge and skills are up to date, and they remain fit to practise; and
- take action to restrict the practice of a registered professional where the required standards of conduct, performance and behaviour are not met

1.2. The UK Parliament is responsible for the regulation of health professions in England and Wales. Regulation of health and care professionals is a devolved matter in Northern Ireland. In Scotland it is devolved for health professionals who entered regulation after the passing of the Scotland Act 1998<sup>6</sup>. This consultation is supported by all governments in the UK.

1.3. There are 32 professions regulated by nine independent healthcare professional regulators. A further 55 occupations are covered by 24 accredited voluntary registers. As outlined in the 2007 Government White Paper *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*<sup>7</sup> the independence of the regulatory bodies is vital 'to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare'. Table 1 below lists the professional regulatory bodies and the professions regulated by each of them.

**Table 1: List of Professional regulatory bodies and regulated professions**

<b>Regulatory body</b>	<b>Acronym</b>	<b>Professions regulated</b>	<b>Number of registrants (including premises where applicable ) 2015/16</b>
General Chiropractic Council	GCC	Chiropractors	3,109
General Dental Council	GDC	Dentists Clinical dental technicians Dental hygienists Dental nurses Dental technicians Dental therapists Orthodontic therapists	108,209
General Medical Council	GMC	Medical practitioners	273,761
General Optical Council	GOC	Optometrists Dispensing opticians Student optometrists Student dispensing opticians Optical businesses	29,136
General Osteopathic Council	GOsC	Osteopaths	5,102
General Pharmaceutical Council	GPhC	Pharmacists in Great Britain Pharmacy technicians in Great Britain Pharmacy business premises in Great Britain	89,377
Health and Care Professions Council	HPC	Arts therapists Biomedical scientists Chiropodists/podiatrists Clinical scientists	341,745

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		Dietitians Hearing aid dispensers Occupational therapists Operating department practitioners Orthoptists Paramedics Physiotherapists Practitioner psychologists Prosthetists/orthotists Radiographers Social workers in England Speech and language therapists	
Nursing and Midwifery Council	NMC	Nurses Midwives	692,550
Pharmaceutical Society of Northern Ireland	PSNI	Pharmacists in Northern Ireland Pharmacy business premises in Northern Ireland	2,852

1.4. Most of the regulatory bodies cover the whole of the UK. The exception to this is the GPhC which regulates pharmacists and pharmacy technicians in England, Scotland and Wales, and the PSNI which regulates pharmacists in Northern Ireland. Additionally the GPhC and the PSNI regulate pharmacy business premises and the GOC regulates optical businesses. The PSNI also has a professional leadership function that the other regulators do not.

1.5. The Children and Social Work Act 2017 received Royal Assent on 27 April 2017. The Act sets the legal framework and paves the way for regulatory reforms that will enable government to establish a new body corporate, Social Work England, which will be a new, bespoke regulator for the social work profession. The Act underpins the Government's ambition to improve the practice of social work and raise the status of the profession. Social Work England will ensure a relentless focus on social work practice – from initial education and training, to continuing professional development. This will be crucial to driving up the quality of social work practice. Reforming regulation in this way is a key plank of the government's stated ambition to improve the status and standing of the social work profession. This approach will be aligned with the principles behind the approach to regulation of all health and social care professions.

1.6. The work of the regulatory bodies is overseen by the PSA. The PSA scrutinises the work of the regulatory bodies by:

- reporting on the performance of the regulators on an annual basis;

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- auditing decisions made during investigations into complaints about a registrant's practice;
- making referrals (or appeals) to the relevant court if it considers that a final fitness to practise decision does not protect the public;
- undertaking research and sharing best practice; and
- undertaking special investigations and providing advice to health ministers in all four UK Governments on regulatory issues.

1.7. The PSA's role will need to evolve to reflect changes in professional regulation and we have included questions on this in this consultation.

1.8. The PSA has published proposals for reform to ensure professional regulation is fit for the future (*Regulation Rethought*, October 2016)<sup>8</sup>. A summary of its proposals are set out in Table 2.

## The Law Commissions' review of professional regulation

1.9. The Law Commissions of England and Wales, Scotland and Northern Ireland published a comprehensive review of the legal framework for professional regulation in the UK in 2014<sup>9</sup>. Alongside this, it also published a draft Bill. The reforms recommended by the Law Commissions aimed to consolidate and simplify the existing legal framework and impose greater consistency across the regulators in some areas, such as the conduct of fitness to practise hearings.

1.10. The government published its response to the Law Commissions' report in January 2015.<sup>10</sup> This consultation builds upon the Law Commissions' recommendations. In the majority of cases there has been no change in the government's position. A summary of where the government's original position on the Law Commissions' recommendations is being reconsidered through this consultation is at Annex A.

## Pre-consultation events

1.11. To prepare for this consultation the four UK governments held a series of stakeholder engagement events throughout the United Kingdom during summer 2016. Nearly 400 people attended five events, including representatives of all four UK governments, regulatory bodies, professional bodies, patient representatives, high street employer representatives, NHS and social care organisations. Discussions took place to gather views and opinions and to identify potential areas for reform.

1.12. These events identified three key themes, which are covered in the following chapters:

- protecting the public;
- responsive regulation; and
- efficient regulation.

Table 2: Key PSA proposals in *Regulation Rethought* (2016)

Theme	Professional Standards Authority proposal
Shared Purpose	Agreement should be achieved regarding a common purpose across the professional regulatory sector. This should be informed through exploration of a common interpretation of regulation and the scope for harmonisation and agreement of common outcomes. There should be adoption of plain English in public-facing communications.
Single Register	Establishment of a shared public-facing register of all health and care professions and occupations.
Common Standards	Agreement on a statement of professional practice, i.e. common professional standards agreed by consensus between regulators and accredited voluntary register holders to apply to all registrants whether licensed or not. Profession/occupation-specific standards should be developed only where needed.
Licensing	Establishment of a licensing regime should be investigated. Language change should be adopted to align with a licensing process, similar to the Driver and Vehicle Licensing Authority. This should be informed through exploration of the scope for issuing licences within existing legislation and proportionate approaches to different professions.
Fitness to Practise	There should be adoption of a shared approach to key elements of the fitness to practise procedures; e.g. the investigation, prosecution and adjudication stages of a case (building on the Medical Practitioners Tribunal Service). Work should be undertaken to explore the scope to further harmonise sanctions and to explore the scope for achieving a more inquisitorial approach within the existing sets of legislation. Regulators should seek to use clearer, more public-focused language. There should be further co-operation with employers to achieve local resolution at an earlier stage where possible.
Co-operation with Others	There should be greater implementation of co-operative working, in particular to use regulatory data and insight in partnership with others to reduce harm.
Education	Work should be undertaken to explore and implement a new approach to align with the licensing regime, based on an assessment of the applicant. There is scope for greater harmonisation of standards and approach to education. Education should be reviewed in view of current and future needs.
Cost-effectiveness	Greater accountability should be introduced for regulators to ensure cost-effective working, including formal assessments of regulators' cost-effectiveness and efficiency.
Right-touch Assurance	Implement the methodology set out in Right-touch assurance: a methodology for assessing and assuring risk of harm.

Source: *Regulation Rethought*, PSA, 2016

## 2. Protecting the public

- 2.1. This chapter considers the architecture of professional regulation: how to decide the right level of regulatory oversight for professional groups and which regulatory bodies have oversight of which professions. Decisions about regulation have to be based on the risk of harm. The case for regulating doctors, nurses, midwives and pharmacists on a statutory basis seems clear. For other professions, particularly new professions, the need for statutory regulation is less clear.
- 2.2. There are currently no formal criteria for determining an appropriate level of regulatory oversight. As a result, professions have been brought into statutory regulation on what can appear to be an ad hoc basis. The HCPC is the only regulator that has the legislative power to recommend that a group should be statutorily regulated. As the HCPC has traditionally been the regulatory body to assume regulatory oversight of new groups, it could be seen to have a vested interest in expanding its registrant base. We therefore believe that the PSA, working with relevant stakeholders, would be better placed to provide advice on the regulation of professions. The ultimate decision regarding whether a group should be regulated would remain with Ministers. While the UK governments recognise that the PSA has powers to accredit voluntary registers, it is not believed this will create a conflict of interest.
- 2.3. The regulation of healthcare professionals should be used proportionately and only where the risks to public and patient protection cannot be addressed in other ways (for example through employer oversight or accredited registers). Without applying a clear criteria professions could be regulated inappropriately
- 2.4. Measuring the risk posed by any particular group of professionals is not easy, particularly in healthcare where professionals face complex situations on a regular basis. Establishing clear criteria to assess the appropriate level of oversight will bring consistency to the decision-making process, helping to ensure that patients and the public receive the right level of protection without placing unnecessary burdens on front-line staff or financial burdens on registrants.
- 2.5. The PSA has set out proposals for assessing whether professional groups should be regulated<sup>11</sup>. It has proposed a two stage assessment.<sup>12</sup> The first stage considers evidence of risk of harm in three key areas. These are:
  - the complexity of the activities/intervention undertaken;
  - where the intervention occurs (for example in a hospital or someone's home); and
  - the vulnerability/autonomy of the patient and their ability to make an informed choice about their care.
- 2.6. The second stage considers wider external policy factors. These could include:
  - the scale of the risk - the size of the professional group or number of patients who are treated;
  - means of assurance - the range of different ways in which the risk of harm can be reduced;
  - sector impact - the impact that regulation (or other means of oversight) would have on cost and supply of the workforce;
  - risk perception - the effect that regulation (or other means of oversight) would have on the confidence levels for the relevant profession; and
  - unintended consequences of the preferred form of oversight.

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- 2.7. This two stage approach to assessing risk would create a risk profile for each professional group to support decisions about the appropriate level of regulatory professional oversight. This model could be applied to all professional groups, including those which are currently subject to statutory regulation, new and emerging professions and existing professions that are not regulated.
- 2.8. The PSA<sup>13</sup> has outlined a range of different types of assurance, on a continuum from routine employer controls to credentialing and voluntary systems of registration. Statutory regulation and licensing is the most stringent form of regulation and should only be applied to higher risk occupations.
- 2.9. In addition, the Law Commissions recommended that regulatory bodies be given powers to operate a form of negative register through the use of prohibition orders for those groups not subject to statutory regulation. Such a scheme allows individuals to be barred from practising a specified profession or from carrying out specific activities and would set the standards required of a certain occupation. Where these standards were not met in a way that places the public at risk of harm, the relevant regulatory body would issue a prohibition order that would prevent or restrict an individual from carrying out a certain role or providing certain services. A breach of such an order could be a criminal offence and employers could be required to check the register of those issued with prohibition orders.
- 2.10. The PSA published *Initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the United Kingdom*, December 2016<sup>14</sup>. A review of the use of prohibition orders has found that there is insufficient evidence on which to draw a conclusion about their effectiveness in a health context. The four UK governments are considering whether prohibition orders should be used as a regulatory approach for some groups of healthcare professionals.

**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?**

**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?**

**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?**

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

## Number of regulatory bodies

- 2.11. There are currently nine regulatory bodies, which range significantly in terms of numbers of individuals regulated and number of professions regulated. Some regulators regulate just a few thousand professionals while others regulate several hundred thousand. The HCPC regulates 16 professions, the NMC regulates two, while others regulate just one profession. As well as regulating professions, the GPhC and the PSNI regulate pharmacy business premises and the GOC regulates optical businesses.
- 2.12. The four UK governments believe there is a case for exploring a reduction in the number of regulatory bodies, possibly to three or four. A reduction in the number of regulators would deliver a more consistent approach to regulation as well as delivering

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savings in the cost of regulation. Having fewer regulators would simplify the landscape, making it clearer to employers, patients and the public who to contact when they have concerns. Fewer regulators would bring greater consistency of standards and in the fitness to practise decision-making process, achieving a fairer outcome for all. In addition fewer, larger regulatory bodies would be able to engage more effectively with all four of the UK governments.

- 2.13. The proposed role of the PSA in recommending which professional groups should be regulated will help inform decisions about how many regulatory bodies there should be and which professions they should regulate.
- 2.14. Reconfiguring the regulatory bodies has the potential to lead to:
- greater clarity for patients and their families/carers about which organisation to contact for what reason, and what can be expected from the process;
  - a clearer system of professional regulation that delivers more effective public protection;
  - greater consistency of approach for the regulatory bodies based on a consistent and flexible set of powers; and
  - maximising the economies of scale that can be achieved by larger bodies.
- 2.15. The four UK governments are seeking views on the principles around reducing the numbers of regulatory bodies and will consider whether to develop proposals for a reduced number of regulators in light of responses to this consultation.

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

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

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

## 3. Responsive regulation

- 3.1. The UK's system of professional regulation needs the flexibility to adapt to new ways of working and to respond appropriately to individual cases. Increasing the responsiveness of the regulatory system will deliver improvements in three main areas:
- investigating and resolving complaints about registrants' fitness to practise more quickly while maintaining high standards of public protection;
  - supporting the professional development of registrants in order to prevent problems emerging or escalating; and
  - responding faster to healthcare delivery and workforce developments.
- 3.2. This chapter considers what improvements can be made to the system of investigating and resolving fitness to practise complaints. It also considers what more the regulatory bodies can do to support the professional development of registrants, ensuring the right training is in place to foster the right behaviours and deliver high quality healthcare. The proposals in this chapter are not dependent on the changes to either those groups that are regulated or to the number of regulatory bodies.
- 3.3. Increasing the responsiveness of professional regulation is not a new idea. The regulatory bodies have already made changes that allow them to work more flexibly. For example the introduction of case examiners who make decisions at the end of the investigation stage of the fitness to practise process at the GMC, the NMC, the GDC and the GOC has led to more consistent decisions being made more quickly. Additionally, the ability of some of the regulators to consensually dispose of cases, for example through the use of undertakings, has sped up the fitness to practise process with fewer cases proceeding to full hearings. This kind of flexible approach should be available to all of the professional regulators.
- 3.4. A range of flexible powers for the fitness to practise processes will not only mean that individual cases can be safely resolved more quickly but it will also allow the regulatory bodies to devote more of their time to supporting the professionalism of all registrants.
- 3.5. Regulators must be attuned to the circumstances in which they operate. Services continually evolve, appetite for risk varies and professional responsibilities change and the regulators need to remain responsive to this changing environment.
- 3.6. The GDC has identified a number of factors that can impact on the ability of professional regulators to operate efficiently. Appreciating these factors is essential to understanding where regulators can intervene to support professionalism ahead of problems occurring. How these factors interact is illustrated in Diagram 1, which highlights a number of external factors (alleviators) that support individuals to act in a professional way. It also shows factors (pressures) that can have a negative impact on the work of professionals. The proposals in this chapter aim to shift the regulatory focus upstream, to support professional standards before the need for fitness to practise proceedings arises.

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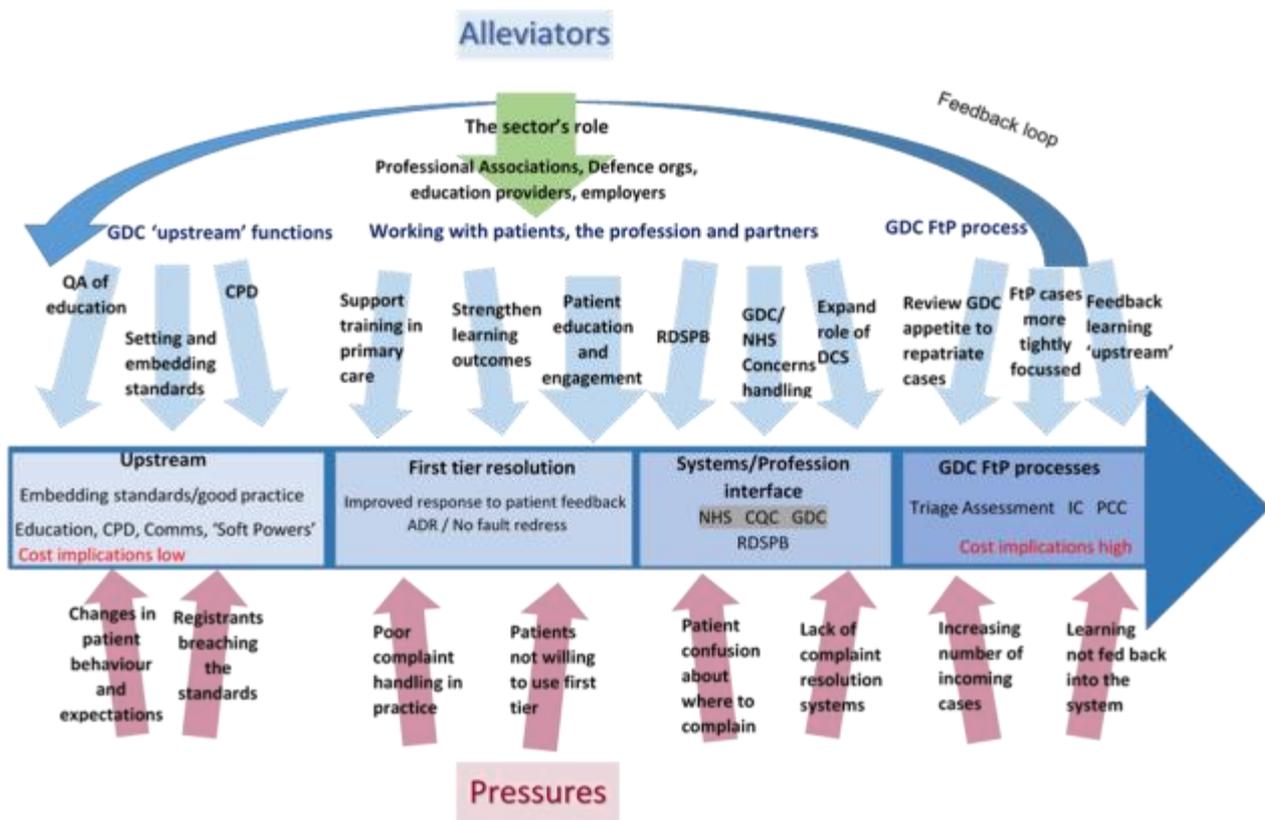


Diagram 1: factors that can impact on the ability of professional regulators to operate efficiently  
Adapted from the GDC, 2016

## A flexible and proportionate approach to investigation and fitness to practise

- 3.7. The current model of professional regulation places a heavy emphasis on dealing with concerns about registrants. Handling fitness to practise concerns must remain a key function of the regulators. However, the existing processes of dealing with allegations made about professionals to their regulators are cumbersome. These lengthy and costly processes are frustrating to patients, registrants and employers alike.
- 3.8. While it is essential that professional regulators provide patients, the public and employers with a clear route for raising concerns about the care that they receive, it is equally important that issues raised are dealt with in a timely, efficient and proportionate manner that delivers strong public protection.
- 3.9. The process for dealing with concerns about registrants varies from regulator to regulator. These processes are legalistic, adversarial, costly and time-consuming. To some extent this is a result of the legislative framework under which the regulators operate. For many of the regulators fitness to practise is their single largest expense. For example fitness to practise cases account for 61% of the General Dental Council's expenditure and 76% of the Nursing and Midwifery Council's expenditure (see Table 3 for more detail).
- 3.10. Table 3 below shows spending on fitness to practise among the regulatory bodies. The variation should not be interpreted as an indication of relative efficiency; differences

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in numbers of fitness to practise cases, the processes and complexity of cases may explain the variation below.

Table 3: Fitness to practise (FtP) expenditure by regulatory body 2015/16

Regulator	FtP* expenditure (£000)		FtP expenditure % of total expenditure	FtP expenditure per registrant	Initial	Average cost per FtP concern	
				(£)	FtP concerns	(£)	
					received		
GCC	6	58	24%	188	4	5	10,846
GDC	2	28,50	61%	263		2,786	10,230
GOC	8	3,58	48%	173	3	34	10,460
GOsC	0	80	29%	157	2	5	15,384
GMC	4	63,23	62%	231		9,418	6,714
GPhC	0	5,44	25%	73		1,939	2,805
HCPC	6	13,18	47%	39		2,127	6,199
NMC	9	58,08	76%	84		5,415	10,727
PSNI	0	14	12%	61	2	2	6,361

Source: Regulators' 2015-16 Annual Reports

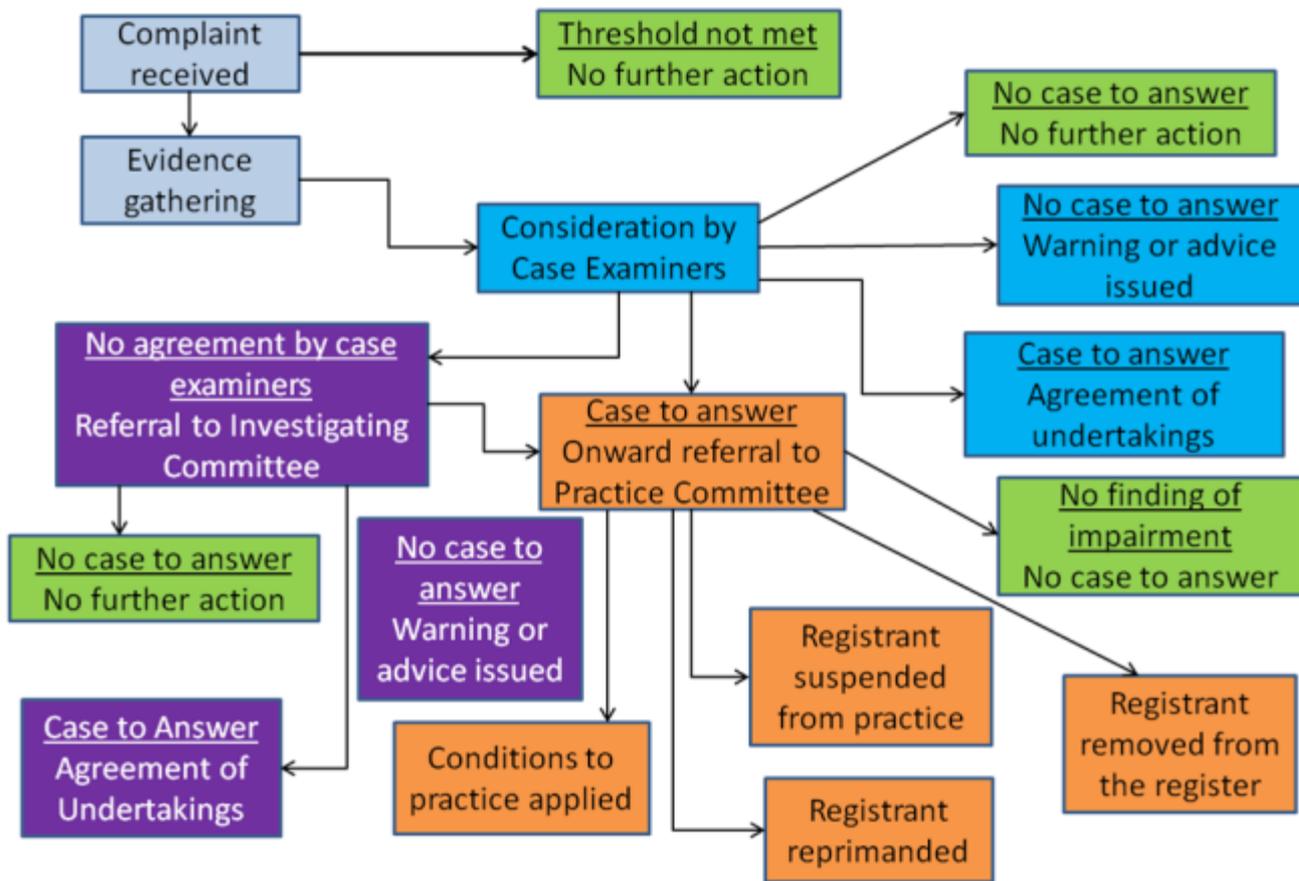
\*Includes triage of the initial allegation received by the regulatory body

\*\*No recent published FtP breakdown for GPhC and PSNI so 2012 CHSEO/PSA unit operating cost used

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3.11. Strong focus on fitness to practise and conducting cases in an adversarial way affects the outlook and culture of the regulatory bodies. The legalistic and defensive nature of the regulators can make them seem unapproachable and bureaucratic to both complainants and registrants. This needs to change. Diagram 2 illustrates the fitness to practise complaint process for the GDC.

Diagram 2: Stages of a Fitness to Practise (FtP) Complaint at the GDC



3.12. There will always be fitness to practise cases where full hearings are appropriate. The consequences of having registration removed are serious, usually resulting in the loss of a person's livelihood. However, this process is not necessary for less serious allegations or where the level of impairment is accepted by the registrant. In these cases a range of powers is required that allows cases to be handled proportionately and clearly protects the public.

3.13. The Law Commissions<sup>15</sup> recommended a number of improvements to the current procedures that would give the regulators greater flexibility and discretion over how to process and investigate fitness to practise cases. Other suggestions made during the pre-consultation stakeholder events included making the triage process more robust and increasing the use of dispute resolution and mediation to manage concerns.

3.14. The regulatory bodies already have a range of options available to address fitness to practise issues. The GMC currently has the broadest range of powers.

3.15. Where the Medical Practitioners' Tribunal Service (MPTS) finds that a doctor's fitness to practise is not impaired, it cannot impose a sanction. However, it may issue a warning if the doctor's conduct, behaviour or performance has significantly departed from the guidance in *Good Medical Practice*<sup>16</sup>.

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- 3.16. Where a tribunal finds a doctor's fitness to practise is impaired it can:
- take no action;
  - accept undertakings that have been agreed between the doctor and the GMC (including any limitations on the doctor's practice) as an alternative to imposing a sanction;
  - impose conditions on the doctor's registration for up to three years;
  - suspend the doctor's registration for up to 12 months; and
  - erase the doctor's name from the medical register, except in cases relating solely to their health and/or knowledge of English.
- 3.17. Interim orders tribunals (prior to assessment by the MPTS) can make an order to suspend a doctor's registration or to impose conditions on a doctor's registration for a maximum of 18 months. Such an order must be reviewed within six months of being imposed and at least every six months thereafter.
- 3.18. This range of powers should mean that regulators are able to take proportionate action in response to the issue that is before them. However, not all of the regulatory bodies have the full range of powers at their disposal. We propose that this range of powers should be available to all of the regulatory bodies.
- 3.19. More needs to be done to move to a more inquisitorial approach that seeks to establish the circumstances of a case rather than an adversarial approach. The government rejected the potential use of mediation as part of the fitness to practise procedures in response to the Law Commissions' recommendations. However we wish to reconsider this in light of the views received during the events held in summer 2016. Dispute resolution or mediation when dealing with enquiries and complaints that do not need a full fitness to practise investigation could help resolution of cases at an earlier stage. We would be interested in hearing views on the value of mediation as part of the system of professional regulation.
- 3.20. If our aim is for the regulatory bodies to support the professionalism of registrants, then they need to be held to account against standards that support and promote this function, as well as against how they handle fitness to practise cases. The PSA is reviewing its *Standards of Good Regulation*<sup>17</sup>, and this review will consider how these standards can reflect the broader role of the regulatory bodies.
- 3.21. The PSA also has powers (under Section 29 of the *National Health Service Reform and Health Care Act 2002*<sup>18</sup>) to refer to court regulators' decisions in fitness to practise cases where it considers the decision is not sufficient for the protection of the public. It is our intention that these powers should be retained to ensure adequate public protection.

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

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

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

## Supporting professionalism

- 3.22. There is more to regulation than fitness to practise. The regulatory system should also support the professional development of all registrants to ensure the workforce has the right skills and experience to deliver high quality care. This includes accrediting courses so that professionals receive good training and education that instil the right skills and behaviours to prevent problems occurring. It also means providing assurance that professionals' skills and behaviour remain fit for purpose throughout their career and supporting the development of a flexible workforce that is responsive to the changing healthcare needs of the population.
- 3.23. Professional regulation is only one component of the system in which professionals operate. Health professionals who are well-trained and well-motivated endeavour to provide excellent care. This is complemented by working in teams with people who are similarly motivated and in organisations which are well-led, are attuned to professional values and are dedicated to the patients and communities they care for.
- 3.24. The 2007 Government White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*<sup>19</sup> set out a number of key principles that should underpin statutory professional regulation. It stated that "professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour". Providing all regulatory bodies with powers to deal with fitness to practise complaints in a more flexible and proportionate way will enable regulators to free up more time to focus on supporting registrants to meet and maintain their professional standards.
- 3.25. This section sets out what more the regulators could do to support professionalism through education, revalidation and continuing professional development.
- 3.26. Progress in this area will be dependent on success in streamlining fitness to practise processes. This will allow the regulatory bodies, working with professional bodies and others, to focus more effort on supporting professionalism in all registrants. This will in turn help create a virtuous circle in which fewer cases require fitness to practise proceedings.

### Improving patient consultations in osteopathy

Since 2013 the GosC has been collecting and aggregating data about complaints, indemnity insurance claims and concerns raised about practitioners by patients. This is a unique partnership between the regulator, insurers and the professional association aimed at understanding common patient concerns that occur in osteopathic practice. The work highlighted concerns about aspects of communication between osteopaths and patients and their impact on the consent process. In addition, research commissioned by the GosC identified factors supporting and inhibiting compliance with standards.

The GosC's response to this has taken a number of forms:

- including the requirement for compulsory activities around communication and consent in its new Continuing Professional Development (CPD) scheme (bespoke learning materials to support the scheme);
- encouraging the development of local osteopathic communities to counteract the

- challenge of professional isolation;
- proposing the provision of more learning resources to support communication, consent and other key areas;
- providing a variety of practice-focused information and case studies in its regular magazine and e-bulletins for registrants;
- working with other regulators and partners on the development of new tools that can be used in practice to support communication between patient and practitioner, and reduce areas of potential complaints; and
- facilitating sessions with providers of both undergraduate education and CPD to ensure that communication and consent are embedded in their activities.

## Education

- 3.27. All of the regulatory bodies are responsible for approving higher education courses which enable entry into the professions that they regulate. They do this by setting the standards of education and training, and visiting education providers to assess whether they meet these standards. Typically, the standards will cover the level of qualification for entry to a profession and standards around admissions, course management and resources, curriculum content, practice placements and assessment methods.
- 3.28. This is a crucial role in assuring the ongoing quality of each profession. There is a wide range of practices across the regulators in the way that they carry this out. This reflects the fact that different occupations require different types and levels of education.
- 3.29. The PSA has suggested that there is some duplication between the regulatory responsibility of professional regulators and other regulators of higher education. It has also recommended that the health professional regulators should focus on setting and assessing the learning outcomes required for registration, leaving other regulators to deal with broader questions of course management.
- 3.30. In future we expect the professional regulators to work in partnership with employers and higher education providers to ensure that the recruitment, education and training systems they assure and operate are delivering the right people, that they are teaching the right things and that skills and behavioural problems identified early in a professional's career are properly addressed.
- 3.31. The UK governments support the PSA's recommendation of a review of the regulatory approach and responsibilities for the education of healthcare professionals. Such a review would aim to ensure that regulators have a clear focus and that they are not duplicating work. The main focus of the professional regulators in this area should be to assure that the higher education institutes produce high quality professionals who are suitable for registration at the end of the course, rather than detailed oversight of the course.

## Continuing fitness to practise

- 3.32. Central to supporting professionalism is ongoing assessment of the fitness to practise of all registrants. All of the regulatory bodies have a system in place, or are devising one, for assessing the continuing fitness to practise of registrants.
- 3.33. For example, revalidation is a system of ongoing checks to encourage reflective practice and ensure practitioners are competent and up to date. It is designed to identify

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good practice and address poor practice before it results in harm to patients. The system brings the registrant into much closer contact with their regulatory body.

- 3.34. The GMC has been operating a formal medical revalidation system since December 2012. This five yearly process requires licensed doctors to demonstrate that their skills and behaviours are up to date and they are fit to practise. It provides doctors with a framework against which to consider their practice. The key element of medical revalidation is a formal annual appraisal that is structured around the GMC's core guidance *Good Medical Practice*<sup>20</sup>.
- 3.35. Revalidation was introduced by the NMC in April 2016. Nurses and midwives are required to revalidate every three years and demonstrate that they are continuing to practise safely and effectively in line with the NMC's code<sup>21</sup>. Revalidation for nurses and midwives covers a number of requirements including practice hours, CPD, practice-related feedback and reflection.
- 3.36. Other regulatory bodies have their own Continuing Fitness to Practise (CFtP) procedures to ensure that their registrants remain fit to practise and that their knowledge and skills remain up to date.
- 3.37. All the regulatory bodies provide advice and guidance to their registrants. For example the GMC's regional and employer liaison service aims to achieve closer engagement with registrants and with the healthcare system. The employer liaison service works to:
- establish good links with Responsible Officers to support an exchange of information about underperforming doctors, improving patient safety and the quality of referrals;
  - share data about underperforming doctors, including regional trends;
  - help Responsible Officers and their teams understand GMC procedures; and
  - support the role of Responsible Officers and employers in relation to revalidation.

### GMC's Regional Liaison Service

Much of the work of the GMC's Regional Liaison Service has been to explore with groups of doctors the practical application of its standards in their working lives. In 2015, the GMC ran workshops across the UK involving 16,733 doctors and 18,493 medical students. Almost 96% of those who responded said that the session they attended would help them reflect on their practice and 75% said they would change their practice as a result. Crucially, these sessions are organised around the feedback received from doctors themselves so that sessions are tailored to their needs and local circumstances.

*Source: GMC*

**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?**

## 4. Efficient regulation

4.1. This section sets out a number of further changes relating to how the regulatory bodies work together and their governance arrangements. As with the changes to fitness to practise procedures, the changes set out in this section are not dependent upon which professional groups are regulated or on the number of regulators.

4.2. In 2015/16 the total operating costs of the 9 statutory regulators was £288m. As Table 4 below shows, they vary significantly in size and the number of professions they regulate.

Table 4: Costs of statutory regulation 2015/16

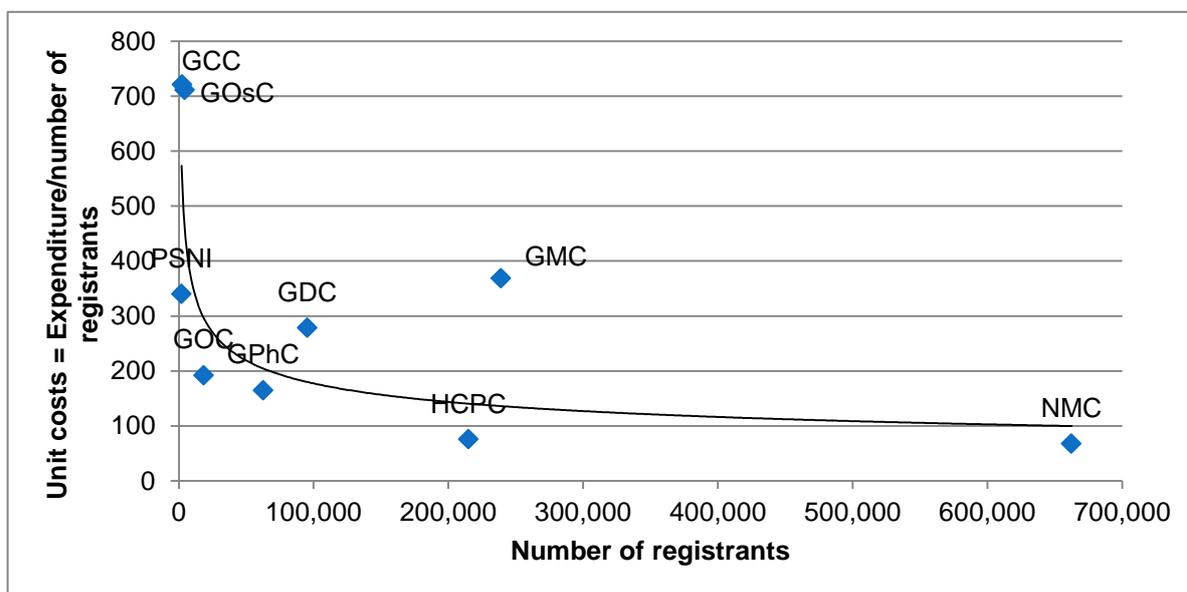
Regulator	No of professions regulated	No of registrants (including business premises where applicable)	% of total registrants	Total operating costs (£'000)	Cost per registrant (£)
GCC	1	3,109	0.2	2,490	801
GDC	7	108,209	7.0	46,685	431
GMC	1	273,761	17.7	101,195	370
GOC*	2	29,136	1.9	7,553	259
GOsC	1	5,102	0.3	2,730	535
GPhC*	2	89,377	5.8	22,062	247
HCPC	16	341,745	22.1	28,287	83
NMC	2	692,550	44.8	76,344	110
PSNI*	1	2,852	0.2	1,124	394
Total	32	1,545,841	100	288,470	187

Source: *Regulators' Annual reports, 2015/16*

\*GOC regulates optical business in UK. GPhC regulate business premises in Great Britain. PSNI regulates pharmacists and business premises for Northern Ireland only and has a professional leadership function for its registrants.

4.3. In November 2012 the PSA analysed the cost effectiveness of the professional regulators<sup>22</sup>. It found a relationship between expenditure per registrant and size of the regulator and wide variation in the cost burden on individual registrants, even though the regulators were carrying out broadly similar statutory functions (Diagram 3).

Diagram 3: Relationship between size of a regulator and unit costs, 2012



Source: <https://www.chseo.org.uk/downloads/report4-costefficiency.pdf> page 12

4.4. Although this data should be interpreted with caution (definitional differences may still explain variation despite attempts by PSA to standardise costs), it does suggest significant economies of scale exist. As a regulator's size increases, unit operating costs (defined as operating costs per registrant) fall and plateau above 300,000 registrants. No significant diseconomies of scale in large regulators were identified.

4.5. Table 5 shows the total operating costs per registrant by core function. For example the amount spent on registration ranges between £11 and £142 per registrant. Variation could be due to a number of factors. These include economies of scale (larger regulators can spread fixed costs over a larger registrant base), complexity of regulation and effectiveness and efficiency. For example the technical complexity of the GMC's fitness to practise cases and their methods for investigating and adjudicating on these may explain some of their higher operating costs. Reporting differences in the allocation of costs to functions may also explain the variation.

Table 5: Total operating costs per registrant (unit costs), £ by function and regulator 2012

	Standards	Registration	Education & training	FtP	Continuing FtP	Governance	Total operating cost per registrant (unit costs)
NMC	5	11	3	42	1	6	68
GMC	6	64	20	244	12	22	368
HCPC	3	16	7	45	0	4	76
GDC	6	63	13	179	3	15	278
GPhC	6	34	22	73	10	20	165
GOC	10	32	24	73	19	34	192
GosC	132	142	53	206	75	105	711
GCC	25	104	0	410	74	108	721
PSNI	23	47	57	66	104	43	340

Source: <https://www.chseo.org.uk/downloads/report4-costefficiency.pdf> page 11

## Joint working

- 4.6. Understanding the reasons for this variation can help to identify the scope for generating greater efficiency within the system and for developing best practice while delivering better public protection. Reducing the number of regulators as proposed in chapter 2 will not only deliver greater consistency in the way that professional regulation is carried out but could also provide an opportunity to deliver cost savings by spreading some fixed costs across a greater number of registrants. There are other changes that can be introduced that will reduce costs while continuing to provide strong public protection and which are not dependent on a reduction in the number of regulatory bodies. These are outlined in this chapter.
- 4.7. The nine UK regulatory bodies all carry out similar functions in relation to different professional groups but undertake these in different ways and under different legislative frameworks. Even without a reduction in the number of regulators there is substantial scope for sharing functions between regulators to deliver a more consistent and cost effective approach.
- 4.8. There have been a number of attempts to promote joint working within the professional regulatory system. These have included simple things such as regulators collaborating to share back-office functions (such as IT and HR) to more complex proposals such as the establishment of the Office of the Health Professions Adjudicator (OHPA). This was

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intended to carry out the adjudication functions of all of the professional regulatory bodies beginning with the GMC and the GOC. For a variety of reasons these initiatives have not been taken forward.

- 4.9. Regulators have also collaborated in developing common standards. For example in 2015 the GMC and NMC worked together to produce joint guidance on registrants' duty of candour. This recognised that the aims and objectives of being open and honest were the same for all professions. This principle could be applied to other general standards for healthcare professionals.
- 4.10. There is a need for a fundamental shift from a system which allows the regulatory bodies to co-operate to one which creates an expectation or places a statutory duty on the regulators to work together.
- 4.11. Working with the regulatory bodies and the PSA, the four UK governments have identified four potential areas where joint working may improve public protection and at the same time generate efficiencies:
- A shared online register, search engine or online portal of all registered healthcare professionals. This will make it easier for patients, the public and employers to access details about whether a health professional is registered and about that professional's registration;
  - A single set of generic standards for all healthcare professionals (underpinned by profession-specific standards owned by the individual regulators). This will ensure that all health professionals are working to the same core set of professional standards. The standards will only differ where there is a profession specific need. This model has been successfully operated by the HCPC for many years;
  - A single adjudicator responsible for all fitness to practise decisions. This will provide greater consistency of decision-making on all fitness to practise cases, making the process fairer for regulated professionals and for patients and the public. This could build on the Medical Practitioners Tribunal Service which considers fitness to practise cases brought by the GMC; and
  - A single organisation conducting back office functions such as HR, finance and IT. Each regulatory body is currently responsible for their back office services. If one organisation was responsible for these functions they are likely to be delivered more efficiently.

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

**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?**

- 4.12. There also needs to be greater co-operation and data sharing between the professional regulators and other parts of the healthcare regulatory system. For example, the GMC, Health Education England and NHS Improvement worked together in response to concerns about the emergency department at North Middlesex University Hospital Trust. However such collaboration does not happen often enough.

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- 4.13. There is a vast amount of intelligence gathered across the system but this is not systematically shared between regulatory partners to ensure that the right body takes the right action at the right time.
- 4.14. For instance, access to provider level data about the number of fitness to practise referrals coming from employers could indicate a problem in the system generally or in a particular organisation. Similarly information held by a system regulator such as the Care Quality Commission about performance at an organisational level might highlight issues with individual professionals which should be investigated by the appropriate professional regulator. The professional regulators will continue to work together and with other regulatory bodies in the health system to make improvements with regard to how they work together to intervene when there are issues with the quality of care.

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

## Autonomy and greater freedoms for the regulatory bodies

- 4.15. It is right that the powers and remit of the regulatory bodies are set in legislation. However, the legislation has been developed over many years and still frequently needs to be amended. Changes to the operating practices of the regulators often require an amendment to primary or secondary legislation. This is costly and time consuming. Where there is a public safety element the time taken to make these changes can compromise public protection.
- 4.16. Providing the regulatory bodies with powers to amend their own procedures would enable them to respond to the changing way that healthcare is delivered without requiring ongoing legislative intervention by government. In taking forward reform of professional regulation we propose to provide regulators with more flexible legislation that will allow them to set more of their own operating procedures.
- 4.17. This approach is not without risk. Autonomy must be balanced with robust accountability to the legislatures across the four countries. The PSA will continue to contribute to the accountability arrangements of the regulatory bodies in that it will continue to report to Parliament on their performance and through appearances before the Health Select Committee. The UK Parliament will continue to hold to account the PSA and the regulators covering the whole of the United Kingdom. The Northern Ireland Assembly will still hold to account the Pharmaceutical Society for Northern Ireland. Moving forwards the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly may also want to hold hearings or take evidence from the regulators and/or the PSA about the impact of their work in that jurisdiction. In addition the regulatory bodies should lay copies of their annual reports, potentially country specific, before all of the UK countries in which they operate to improve their accountability to each legislature.

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

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

## Governance

- 4.18. The previous section set out the case for providing greater autonomy to the regulators. This must be balanced by effective governance. There has been much progress toward this over the last ten years. Moving from a system of professional self-regulation to independent regulation has led to greater scrutiny, as has regular accountability hearings before the House of Commons' Health Select Committee.
- 4.19. The councils of most of the regulatory bodies consist of 12 independent non-executive members half of whom are registrants. While this is a clear improvement there remain vestiges of the old system of self-regulation which need to be addressed. The concept of members of the councils representing the profession being regulated is at odds with a system of independent regulation. While the councils or boards of the regulators clearly need to have detailed knowledge of the professions that they regulate, which may well be provided by members of those professions, council members are not sitting in a representative role on behalf of their profession. Rather they are there to provide the skills, knowledge and expertise to hold the body to account. In addition, currently the councils do not include the executive members of the regulator. This can make it difficult for the councils to hold the regulator to account.
- 4.20. The Committee on Standards in Public Life published a report in September 2016, *Striking the Balance - upholding the 7 principles in regulation*<sup>23</sup>, which highlights that the current two tier structure cannot support effective accountability to Parliament/government because the Councils make decisions but it is the executive that carries out the work. Therefore in practice it is the executive that is held to account for decisions it has not taken and may or may not have managed to influence.
- 4.21. The four UK governments believe that it is time to take the next step in the journey away from self-regulation and to explore a modernised governance structure for the regulators. This would involve the establishment of a new board structure which comprises both non-executive and executive directors. The non-executive directors, including the chair, would be selected to ensure that there is the right mix of skills and experience to ensure the regulator is robustly scrutinised. The distinction between representative and public members would be removed, although it would be extremely likely that the non-executive members would include people who are in the professions regulated, but these would not form more than half of the Board. The non-executive members would be appointed by the Privy Council as they are now to ensure independence from government.
- 4.22. The executive members of the Board would be the senior employees of the regulator and would be appointed by the non-executive members. Their presence on the Board would enable the non-executives to hold the executives to account in a thorough fashion.
- 4.23. The regulatory bodies have a role along with others within the healthcare system in ensuring we have the right workforce, with the right skills and behaviours, educated to the right professional standards, with the right professional values in place. It is therefore important that the regulatory bodies recognise this and work closely with employers who recruit and employ that workforce. The four UK governments wish to explore how this is best achieved.

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

**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?**

**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?**

## Registration fees

4.24. Regulators are responsible for the fees that they charge to registrants. Some regulators charge different fees for different professions, for example the GDC charges dentists £890 while other dental care professionals are charged a lower fee of £116. Additionally the PSA is funded by a fee raised from the regulatory bodies it oversees. The fees charged to registrants therefore also cover this cost. Table 6 below sets out the current fees charged.

Table 6: Annual retention fees, 2015/2016

Regulator	Fee (£)
GCC	800
GDC	116 - 890
GMC	425
GOC	320
GosC	570
GPhC	118 - 250
HCPC	90
NMC	120
PSNI*	326

Source: Regulators' 2015/2016 annual reports

\*Leadership is not separated in PSNI in the same way as other regulators – a part of the fee is provided to a leadership body. The fee shown is that relating to the regulatory function only.

4.25. The four UK governments have been clear that fee rises should be kept to a minimum. This continues to be our position. Reform of professional regulation is likely to deliver more efficient regulation and there is a case for passing on at least some of the savings to registrants in the form of lower fees, in addition to investing in work to support

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professionalism. We would welcome the views of respondents about whether savings arising from changes to the fitness to practise process should be invested in supporting professionalism, should be returned to registrants in lower registration fees, or both. There may be other areas where any savings should be reinvested.

**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?**

## 5. Impact assessment

- 5.1. The aims of the reforms are to simplify, streamline and modernise the legislative framework for healthcare professional regulation. As part of this consultation a high level assessment of the options for delivering reform has been developed.
- 5.2. It is expected the impacts overall will be positive and deregulatory to business. The impacts of amending the legislative framework are expected to fall on a wide range of stakeholders including: the existing healthcare professional regulators; the PSA which oversees the activity of the regulators; the regulators' registrants (a proportion of whom undertake the majority of their professional activity in the private sector and therefore are classified as businesses); patients; the wider public and government. Most of the costs and savings will impact on the regulatory and wider healthcare sector.
- 5.3. Table 7 below sets out initial high level assessment of impacts.
- 5.4. There are likely to be health benefits to patients, families and wider society as a result of the reforms by providing better protection to the public and improving confidence in the regulatory bodies.
- 5.5. The four UK governments would like to gather further evidence on the scale of this as part of the consultation and would welcome views on the types of health benefits (improved public protection and patient safety) likely and, if possible, to quantify these benefits so they can be included in the impact assessment.

**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.**

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

Table 7: High level assessment of impacts

Stakeholders	Positives	Negatives
Patients/wider public	<p>Improved patient safety</p> <p>Improved quality of care</p> <p>Faster resolution of concerns</p> <p>Greater transparency on processes</p> <p>Improved fairness of processes between professionals</p>	<p>Time taken to deliver reform</p>
Individual registrants	<p>Potential reduction in fees for regulated professionals</p> <p>Savings for any deregulated professions</p> <p>Better supported through improved standards/CPD</p> <p>Improved public perception of regulated professionals</p>	<p>Reduced status for de-regulated professional</p>
Regulatory Bodies	<p>Greater autonomy to amend own procedures</p> <p>Larger registrant base so higher income from fees</p> <p>Cost savings from ability to be more flexible in functions e.g. registration, fitness to practise.</p>	<p>Higher operating costs for merged regulators</p> <p>Smaller regulatory bodies closed down</p> <p>Transition costs involved in implementing changes</p>
PSA	<p>Fewer regulators, so increased PSA capacity for oversight of each one</p> <p>Opportunity for more economic use of resources e.g. away from FtP related towards preventative regulation</p> <p>Opportunity to ensure proportionate regulation</p>	<p>Increased use of consensual disposals could mean reduced oversight of FtP outcomes, therefore reduced ability to protect the public</p> <p>Impact of mergers could mean temporary dip in performance, therefore increased workload for PSA</p>

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Taxpayers/government	Lower central administrative costs of maintaining the legislation  Small increase in tax revenue from registrants that are deregulated, as they will no longer be entitled to tax break.  Improved fairness of processes between professionals	Upfront costs of delivery of reform.
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## 6. Equality analysis

- 6.1. The Department of Health, the Devolved Administrations and the professional regulatory bodies are covered by the Equality Act 2010 and specifically the Public Sector Equality Duty.
- 6.2. The Duty covers the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex and sexual orientation.
- 6.3. There are three parts to the Duty and public bodies must, in exercising their functions, have due regard to them all. They are:
  - the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
  - advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
  - foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- 6.4. Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard in particular to the need to:
  - remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
  - take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
  - encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low. The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include in particular steps to take account of disabled persons' disabilities.
- 6.5. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular to the need to:
  - tackle prejudice;
  - promote understanding.
- 6.6. Section 75(1) of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity between:
  - persons of different religious belief, political opinion, racial group, age, marital status and sexual orientation;
  - men and women generally;
  - persons with a disability and persons without;
  - persons with dependants and persons without.
- 6.7. In addition section 75(2) of the 1998 Act requires public authorities without prejudice to their obligations under subsection (1) to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion and racial group.

**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?**

## 7. 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?

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?

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?

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

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

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

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

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

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

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

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?

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?

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

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?

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

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

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?

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?

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?

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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?

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?

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.

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

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?

## 8. Responding to the consultation

### Consultation process

- 8.1. This document launches a consultation on a number of proposals concerning UK healthcare professional regulatory reform.
- 8.2. The consultation is being run as far as is practical in accordance with the Cabinet Office Code of Practice on Consultations (reproduced below).
- 8.3. The closing date for the consultation is 23 January 2018.
- 8.4. There is a questionnaire on the gov.uk website which can be printed and sent by post to:

UK Healthcare Professional Regulatory Reform Team Professional Regulation Department of Health 2W09 Quarry House Quarry Hill LEEDS LS2 7UE
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- 8.5. Completed questionnaires can also be sent electronically by email to: [reformingregulation@dh.gsi.gov.uk](mailto:reformingregulation@dh.gsi.gov.uk)
- 8.6. Alternatively you may also complete the online consultation response document at: <http://consultations.dh.gov.uk>
- 8.7. It will help us to analyse the responses if respondents fill in the online consultation response document but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than in pdf format.

### Criteria for consultation

- 8.8. This consultation follows the Government Code of Practice. In particular we aim to:
  - formally consult at a stage where there is scope to influence the policy outcome;
  - consult for a sufficient period;
  - be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
  - ensure the consultation exercise is designed to be accessible to and clearly targeted at those people it is intended to reach;
  - keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
  - analyse responses carefully and give clear feedback to participants following the consultation;

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- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

8.9. The full text of the code of practice is on the Better Regulation website at:  
[www.bis.gov.uk/policies/better-regulation/consultation-guidance](http://www.bis.gov.uk/policies/better-regulation/consultation-guidance)

## Confidentiality of information

8.10. We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter:  
[www.dh.gov.uk/en/FreedomOfInformation/DH\\_088010](http://www.dh.gov.uk/en/FreedomOfInformation/DH_088010)

8.11. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

8.12. If you want the information that you provide to be treated as confidential please be aware that under the FOIA there is a statutory Code of Practice which public authorities must comply with and which deals amongst other things with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not of itself be regarded as binding on the Department.

8.13. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary of consultation responses

8.14. A summary of the responses to this consultation will be made available before or alongside any further action and will be placed on the GOV.UK website ([www.gov.uk/dh](http://www.gov.uk/dh)).

## Annex A: Law Commissions' recommendations

The Law Commissions of England and Wales, Scotland and Northern Ireland published a comprehensive review of the legal framework for professional regulation in the UK in 2014<sup>24</sup>. Alongside this, it also published a draft Bill. The reforms recommended by the Law Commissions would consolidate and simplify the existing legal framework and would impose greater consistency across the regulators in some areas, such as the conduct of fitness to practise hearings.

The government published its response to the Law Commissions' report in January 2015<sup>25</sup>. In the majority of cases there has been no change in the government's position. A summary of where the government's original position on the Law Commissions' recommendations is being tested is set out below.

No.	Recommendations	Original response	Original response (detail)	Original response still stands?	Current Policy/Approach
8	The formal role of the Privy Council in relation to health and social care professionals' regulation should be removed entirely.	Accept in part	It is the Government's view that the Privy Council should retain its powers. The exception is the case of approval of regulatory bodies' rules, which will be subject to the outcome of the Government's further consideration mentioned at recommendation 3. This position on the role of Privy Council is given further consideration under recommendations 9, 10, 16 and 19.	To test	<p>This consultation seeks views on whether the Privy Council's role in professional regulation should be reduced, with the regulatory bodies being given greater powers to set their own rules.</p> <p><b>See: 'Autonomy and greater freedoms for the regulatory bodies' section of consultation paper.</b></p> <p><b>Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?</b></p> <p>This position also applies to the following recommendations made by the Law Commissions: 9, 10, 19, 16, 45 and 46</p>
12	The regulators' annual reports,	Accept in	We do not agree that it is necessary to change	To test	The consultation is seeking views whether the regulatory

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	<p>strategic plans and accounts should be laid in the UK Parliament, Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly.</p>	part	<p>the current position as to the Parliaments in which regulatory bodies are required to lay reports etc. These should reflect devolution arrangements.</p>		<p>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.</p> <p>See: ‘Autonomy and greater freedoms for the regulatory bodies’ section of consultation paper.</p> <p>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?</p>
31	<p>The Government should have regulation making powers to establish barring schemes, to be run by the regulators. Such a scheme could be introduced in respect of a prescribed health or social care profession, a specified field of activity, a role involving supervision or management, and prescribed title.</p>	Accept	<p>The Government agrees that prohibition orders may have utility in the future in regards to specific areas of practice which are currently unregulated or in emerging areas of risk.</p>	To test	<p>In December 2016, the PSA published a report giving an initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the UK. The consultation seeks views on the use of prohibition orders as an alternative to statutory regulation.</p> <p>See: Section 2 – Protecting the Public.</p> <p><b>Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?</b></p>
69	<p>The Government’s regulation-making powers</p>	Do not accept	<p>We share the Law Commissions’ analysis of the appropriateness of mediation in the</p>	To test	<p>In light of the views received during the events across summer 2016 the consultation seeks views on</p>

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<p>should include the power to introduce mediation for one or more of the regulators.</p>	<p>fitness to practise context. It is not clear how mediation sits with the objective of the fitness to practise procedures to protect the public, uphold proper standards of conduct and behaviour and maintain confidence in the relevant profession. We also agree with the Law Commissions that mediation is likely to only be of utility where a referral has been made that does not amount to an allegation of impaired fitness to practise, as otherwise the regulatory body should be obliged to pursue regulatory action.</p>	<p>whether using dispute resolution or mediation could help the regulators to resolve concerns at an earlier stage in the process, before being referred in to the very expensive and stressful FtP procedures.</p>
	<p>Because of these reasons, the Law Commissions have proposed that any mediation scheme should be controlled by a Government regulation making power. However we do not think that such a power is required as we do not consider that mediation should have any statutory footing within the context of the fitness to practise procedures.</p>	<p>See: 'A flexible and proportionate approach to investigation and fitness to practise' section of consultation paper.</p>
		<p><b>Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?</b></p>
		<p><b>Q9: What are your views on the role of mediation in the fitness to practise process?</b></p>

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74	<p>All fitness to practise hearings should be conducted by a panel of at least three members (including at least one lay member). Members of the regulatory bodies (including those from other regulators), members of the Professional Standards Authority's board, and investigators should be prohibited from membership of fitness to practise panels. The regulators would have rule-making powers on other aspects of panels, such as the appointment of advisers and legal chairs.</p>	Accept	<p>As set out in Chapter 1, the Government will wish to consider the best balance as to which provisions should be in any future Government Bill and which would be suitable for rules as well as suitable oversight arrangements. We agree that the membership of a fitness to practise panel should consist of at least one lay and one registrant member. We would also want to prohibit a registrant majority. This would mean that where a panel was constituted of three members, two would be lay. We may also want to expand the list of persons prohibited from sitting on a fitness to practise panel to secure, as far as possible, the separation between the investigation and adjudication of fitness to practise cases.</p>	To test	<p>This consultation seeks views on whether the regulatory bodies should be given a broad range of powers to consider fitness to practise, and more powers to set their own procedures.</p> <p>See: 'A flexible and proportionate approach to investigation and fitness to practise' section of consultation paper.</p> <p><b>Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?</b></p> <p>This stance also applies to the following recommendations made by the Law Commissions: 77, 78, 83, 86, 87 and 88</p>
107	<p>The Government should have powers to make appointments to the Professional Standards Authority's board. The administration of appointments would be undertaken by</p>	Do not accept	<p>The Government does not agree with the removal of the Privy Council role in this appointments process. We feel the PSA board should continue to consist of a chair who is appointed by the Privy Council. Of the six non-executive members, three should be appointed by the</p>	To test	<p>This consultation seeks views on whether the Privy Council's role in professional regulation should be reduced, with the regulatory bodies being given greater powers to set their own rules.</p> <p>See: 'Autonomy and greater freedoms for the regulatory bodies' section of consultation paper.</p>

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	the Professional Standards Authority in accordance with its guidelines and standards.		Privy Council and one each by the administrations in Scotland, Wales and Northern Ireland.		<b>Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?</b>
111	A regulator may dispense with the duty to consult in a particular case if it considers that it would be inappropriate or disproportionate to consult, and approval has been given by the Professional Standards Authority.	Accept in part	As set out in Chapter 1 the Government intends to consider further the balance between primary legislation and rules and regulations and accompanying safeguards and oversight arrangements and within this it will need to consider such consultation duties and the scope (if any) for dispensing with them. The Government agrees that a regulatory body may dispense with the duty to consult where it considers such a step to be disproportionate or inappropriate. We disagree that approval should be required from the PSA on the basis this is an unnecessary restriction and could create a conflict of interest for the PSA in assuring the quality and robustness of the decisions and actions of the regulatory bodies.	To test	<p>This consultation seeks views on whether the Privy Council's role in professional regulation should be reduced, with the regulatory bodies being given greater powers to set their own rules.</p> <p><b>See: Autonomy and greater freedoms for the regulatory bodies section of consultation paper.</b></p> <p><b>Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?</b></p>

## Annex B: Glossary

ABBREVIATIONS AND TERMS	EXPLANATION
Accredited registration/Assured voluntary registration	The Professional Standards Authority for Health and Care assesses and accreditd organisations that register health and social care practitioners who are not statutorily regulated.
Case Examiners	Case examiners make the decision at the end of the investigation stage of the fitness to practise procedures/process, on behalf of the Investigating Committee.
Consensual disposal	Consensual disposal can be used by the professional regulatory bodies, in appropriate cases. Consensual disposal is the conclusion of cases at the investigation stage of the fitness to practise procedures/process and is an alternative to referring the case forward for a fitness to practise panel hearing, whilst satisfactorily protecting the public.
Continuing Professional Development (CPD)	All professionals registered with a professional regulatory body are required to continue to develop their knowledge and skills while they are registered.
Continuing fitness to practise	Continuing Fitness to Practise (CFtP) procedures ensure that registrants remain fit to practice and that their knowledge and skills remain up to date.
Council	The Council is the governing body of the professional regulatory body.
Education and training	The professional regulatory bodies are responsible for assessing education and training programmes.
Equality Analysis	A process evaluating the impact of the proposed policy on the equality principles.
Fees	To be registered with a professional regulatory body, professionals must pay a fee.
Fitness to practise (FtP)	The skills, knowledge and character required of professionals to practise their profession safely and effectively.
Fitness to practise (FtP) procedures/process	Investigations into allegations made about professionals to their professional regulatory bodies are known as the 'fitness to practise' procedures.
General Chiropractic Council (GCC)	Professional regulatory body responsible for regulating chiropractors. <a href="http://www.gcc-uk.org/">http://www.gcc-uk.org/</a>

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General Dental Council (GDC)	Professional regulatory body responsible for dental professionals. <a href="https://www.gdc-uk.org/">https://www.gdc-uk.org/</a>
General Medical Council (GMC)	Professional regulatory body responsible for regulating medical practitioners. <a href="http://www.gmc-uk.org/">http://www.gmc-uk.org/</a>
General Optical Council (GOC)	Professional regulatory body responsible for regulating optometrists, dispensing opticians, student opticians and optical businesses. <a href="https://www.optical.org/">https://www.optical.org/</a>
General Osteopathic Council (GOsC)	Professional regulatory body responsible for regulating osteopaths. <a href="http://www.osteopathy.org.uk/home/">http://www.osteopathy.org.uk/home/</a>
General Pharmaceutical Society (GPhC)	Professional regulatory body responsible for regulating pharmacists, pharmacy technicians and pharmacy business premises in Great Britain. <a href="http://www.pharmacyregulation.org/">http://www.pharmacyregulation.org/</a>
Health and Care Professions Council (HCPC)	Professional regulatory body responsible for regulating arts therapists, biomedical scientists, chiroprodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England and speech and language therapists. <a href="http://hcpc-uk.co.uk/">http://hcpc-uk.co.uk/</a>
Impact Assessment	A process evaluating the economic impact of the proposed policy.
Investigating Committee	Makes the decision at the end of the investigation stage of the fitness to practise procedures/process.
Law Commissions of England and Wales, Scotland and Northern Ireland	Independent bodies designed to keep the law under review and to recommend reform where it is needed.
Medical Practitioners Tribunal Service	The Medical Practitioners Tribunal Service is the adjudication service for United Kingdom doctors.
NHS Five Year Forward View	The plan for the next five years for the NHS.
Nursing and Midwifery Council (NMC)	Professional regulatory body responsible for regulating nurses and midwives. <a href="https://www.nmc.org.uk/">https://www.nmc.org.uk/</a>

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Office of the Health Professions Adjudicator	OHPA was originally set up to take over Fitness to Practice hearings from the General Medical Council from 1 April 2011 and those from the General Optical Council at a later date. However it was closed before it became operational. It was abolished in 2012.
Pharmaceutical Society of Northern Ireland (PSNI)	Professional regulatory body responsible for regulating pharmacists and pharmacy business premises in Northern Ireland, and has a professional leadership function for its registrants. <a href="http://www.psni.org.uk/">http://www.psni.org.uk/</a>
Privy Council	The Privy Council is the mechanism through which agreement is reached on items of government business which fall to Ministers as Privy Counsellors rather than as Departmental Ministers. The Privy Council currently has a role in various aspects of statutory professional regulation.
Professional regulatory bodies	The organisations responsible for protecting the public by: Setting the standards of behaviour, competence and education that health professionals must meet; Dealing with concerns from patients, the public and others about health professionals who are unfit to practise because of poor health, misconduct or poor performance; Keeping registers of health professionals who are fit to practise in the United Kingdom; The regulators can remove professionals from their registers and prevent them from practising if they consider this to be in the best interests of the public.
Professional Standards Authority for Health and Social Care (PSA)	Established in 2002 to promote greater consistency and responsiveness from the health regulators. It conducts annual performance reviews, promotes good practice, provides specific advice to government when commissioned to do so and undertakes special investigations as required. It also has the power to challenge fitness to practise decisions that it regards as insufficient to protect the public. <a href="https://www.professionalstandards.org.uk/contact-us">https://www.professionalstandards.org.uk/contact-us</a>
Registration	Those professionals practising a statutorily regulated profession must apply to join the appropriate organisation's register. The professional regulatory bodies are responsible for: <ul style="list-style-type: none"> <li>• allowing access to the register for those professionals who meet the standards</li> <li>• continuing registration for those professionals who meet the standards</li> <li>• removing those individuals who no longer meet the standards</li> </ul> <p>It is a criminal offence for an individual to practice a statutorily</p>

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	regulated profession without being listed on the appropriate register.
Revalidation	Revalidation is a system of ongoing checks to encourage reflective practice and make sure practitioners are competent and up to date. It is also designed to help identify good practice and address poor practice behaviours before it results in patient harm.
Right-touch regulation	<i>Right-touch regulation</i> has been developed by the Professional Standards Authority for Health and Social Care and is aimed at making sure the level of regulation is proportionate to the level of risk to the public. ( <i>Right-touch Regulation, PSA, 2015.</i> )
Self-regulation	Where professionals themselves are responsible for policing their own conduct, performance and behaviour.
Shared regulation	Encompassing both the public and professionals in the oversight of regulation.
Standards	The professional standards that professionals must uphold in order to be registered to practise a statutorily regulated profession in the United Kingdom.
Statutory professional regulation	The framework around which professional groups which are regulated by statute are required to register with the appropriate regulatory body and to meet the standards of practise set by those organisations.  It is a criminal offence for an individual to practice a statutorily regulated profession without being listed on the appropriate register.
System regulation	This involves regulation of the quality and safety of care delivered by providers and regulation of the market in healthcare services.
Undertakings	Undertakings are an agreement between a professional regulatory body and a registered professional about their future practice. Undertakings are used, in appropriate cases, during the fitness to practise procedures/ process and are a form of consensual disposal.
Unitary Board	Board structure which comprises both non-executive and executive directors.
'Upstream'	The early intervention activities which the government proposes the professional regulatory bodies should take support professionals at an earlier stage to reduce the need for action at the fitness to practise stage.

## 9. References

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- <sup>1</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- <sup>2</sup> <http://www.gov.scot/Publications/2016/02/8699>
- <sup>3</sup> <https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf>
- <sup>4</sup> <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>
- <sup>5</sup> <https://www.chseo.org.uk/downloads/report4-costefficiency.pdf>
- <sup>6</sup> Professions regulated following the Scotland Act 1998: operating department practitioners and practitioner psychologists, regulated by the Health and Care Professions Council; dental nurses, dental technicians, clinical dental technicians and orthodontic therapists, regulated by the General Dental Council and pharmacy technicians, regulated by the General Pharmaceutical Council.
- <sup>7</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228847/7013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf)
- <sup>8</sup> <http://www.professionalstandards.org.uk/publications/detail/regulation-rethought>
- <sup>9</sup> [http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345\\_regulation\\_of\\_healthcare\\_professionals.pdf](http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf)
- <sup>10</sup> <https://www.gov.uk/government/publications/regulation-of-health-and-social-care-professionals-response>
- <sup>11</sup> <http://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm>
- <sup>12</sup> <http://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm>
- <sup>13</sup> <http://www.professionalstandards.org.uk/docs/default-source/publications/regulation-rethought.pdf>
- <sup>14</sup> <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/feasibility-of-prohibition-order-schemes---initial-evaluation.pdf>
- <sup>15</sup> [http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345\\_regulation\\_of\\_healthcare\\_professionals.pdf](http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf)
- <sup>16</sup> [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)
- <sup>17</sup> <http://www.professionalstandards.org.uk/publications/detail/standards-of-good-regulation>
- <sup>18</sup> <http://www.legislation.gov.uk/ukpga/2002/17/part/2/crossheading/the-council-for-the-regulation-of-health-care-professionals>
- <sup>19</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228847/7013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf)
- <sup>20</sup> [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)
- <sup>21</sup> <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>
- <sup>22</sup> Professional Standards Authority estimated that these begin to be realised in a registrant base of between 100k and 200k individuals: <http://www.professionalstandards.org.uk/docs/default-source/publications/special-review-report/cost-effectiveness-and-efficiency-review-health-professional-regulators-2012.pdf>
- <sup>23</sup> <https://www.gov.uk/government/publications/striking-the-balance-upholding-the-7-principles-in-regulation>
- <sup>24</sup> [http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345\\_regulation\\_of\\_healthcare\\_professionals.pdf](http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf)
- <sup>25</sup> <https://www.gov.uk/government/publications/regulation-of-health-and-social-care-professionals-response>