The regulation of the non-medical healthcare professions

A review by the Department of Health
Summary of decisions

Ministers have come to the following conclusions as a result of the review, subject to consultation.

1. Regulation of the professions should be co-ordinated with the regulation of health services; build on systems used by employers (and NHS commissioners) where possible; form one integrated and consistent framework of regulation across the different professions, in which departures from the standard approach need objective justification in terms of public protection; and adopt a risk-based approach, in which any new regulatory activities must be as simple and light touch as is consistent with their patient safety goals. (chapter 1)

2. Regulators should be more consistent with each other about the standards they require of a person entering the register for the first time, and employers and regulators should agree on common standards as far as possible. All regulators should adopt a single definition of “good character”, one of the legal requirements for getting registration. This should be based on objective tests. (chapter 2)

3. When a professional starts their first job they have to get onto a regulator’s register and satisfy the requirements of their employer. Employers and regulators should co-ordinate their information requirements so that the person provides each piece of information only once. (chapter 2)

4. Revalidation is necessary for all professionals. The regulatory body needs to be in charge of setting the standard which a person must meet to stay on the register. Information already collected by the employer/commissioner should be used to meet both their and the regulator’s needs. (chapter 3)

5. The revalidation system should be both formative (an aid to development) and summative (a check that a required standard is met). Within the NHS, information gathered under the Knowledge and Skills Framework (KSF) should be the basis of revalidation. Any additional requirements should be justified by risk analysis. Professionals will fall into one of three groups for revalidation:
   - employees of an approved body – revalidation carried out as part of the routine staff management or clinical governance system.
• self-employed staff providing services commissioned by NHS primary care organisations – revalidation processes built into the relevant NHS arrangements and carried out under the supervision of the commissioning organisation

• all others – regulatory bodies develop direct revalidation arrangements. (chapter 3)

6. The Healthcare Commission in England (or its equivalent in each of the other UK countries) should approve employers who can deliver reliable revalidation processes. (chapter 3)

7. In addition to information from existing clinical governance systems, further information will be needed for a reliable assessment that a person remains fit to practise. This should however be proportionate and based on risk assessment. (chapter 3)

8. Post-registration qualifications should be recorded in the register where the specialisation is relevant to patient care and patient safety, can be defined in terms of extra skills acquired, and is at a level substantially beyond basic registration. (chapter 3)

9. There should be a single source of advice to those who want to express concerns about registrants and a single investigation process at local level that would provide a report and evidence that would, where possible, meet the various needs such as resolving a complaint and deciding whether to refer to a regulator. Any investigation needs to determine what actually happened. (chapter 4)

10. The Council for Healthcare Regulatory Excellence (CHRE) should organise the agreement of protocols for local investigation which would ensure that their findings of fact could be relied on by regulators if a case had to go to them for resolution. Their audit role should be extended to include a duty to sample decisions taken by regulators not to proceed to formal investigation of cases referred to them (chapter 4)

11. Employers should remain ready to refer the most serious cases to the national regulator, that is, every case where investigation might lead to removal from the register. (chapter 4)
12. The task of adjudicating on concerns about impaired fitness to practise should be carried out either (a) by a single separate adjudicator for all the professions; (b) as now for the non-medical professions, or (c) under the control of regulators as now, but by shared panelists working to common standards. Comments are invited on this.

13. Each panel hearing a case about fitness to practise would include lay and professional members; the latter selected with regard to the area in which the person appearing was working. (chapter 4)

14. The Scottish pilot of employer-led regulation of support workers, which should provide important evidence about whether this is the best way to proceed, will continue until the end of 2006. A successful outcome for the pilot could lead to the adoption of a UK-wide employer-led approach to the regulation of this group of workers. (chapter 5)

15. The new roles using the working titles of Anaesthesia Practitioner, Emergency Care Practitioner, Endoscopy Practitioner, Medical Care Practitioner and Surgical Care Practitioner need statutory regulation, if healthcare providers agree they are fit for purpose. Work remains to be done about the exact form this should take: whether they should be regulated as one group with specialisms, or as up to five separate groups. (chapter 6)

16. One or more existing regulators will become the “lead regulator” for new groups. The lead regulator will set the standards applying to everyone registering as a member of the new group. Where someone joins the new group from an existing profession, they can remain registered with their existing regulator and avoid costly dual registration. (chapter 6)

17. All regulators have the same role of protecting the public. Where existing legislation adds other roles of professional leadership and promoting the profession, as for example in pharmacy, these should be explicitly and exclusively exercised for the public benefit. The implementation of changes following this review will provide opportunities to bring the regulation of these professions into line with the majority. (chapter 7)
18. There are substantial areas in which common standards would be desirable – in particular most aspects of conduct. The more difficult task of identifying common educational standards in areas such as the knowledge needed to underpin safe prescribing should not be ducked either. The regulators and CHRE should work to introduce common standards in all those areas where this would benefit patient safety. (chapter 7)

19. Some or all of the elected professional members of Councils should be replaced by appointed professional members. A clear person specification is required, identifying desirable qualities. Professional majorities on each regulatory body could remain, but they should in future be made up differently, with most or all professionals appointed rather than elected. (chapter 7)

20. Comments are invited on the future balance of Councils between professional and lay members, with the possibility of either a professional majority of one, a lay majority of one or no change. (chapter 7)

21. Changes are needed to the membership of CHRE’s Council which will preserve its lay majority (and UK-wide makeup) while securing a professional voice through appointments against objective criteria, in place of the existing ex officio membership of Regulatory Bodies’ Presidents. (chapter 7)

22. A regulator like the Health Professions Council, dealing with a range of disparate professional groups, can deliver the functions which public protection requires. Professional bodies dedicated to providing leadership and setting standards are also needed: the two work together. (chapter 7)

23. Any new profession coming into statutory regulation should be regulated by one of the existing regulatory bodies, most likely the HPC. (chapter 7)

24. The Pharmaceutical Society of Northern Ireland (PSNI) should remain as an independent body for the time being but with shared functions with the Royal Pharmaceutical Society of Great Britain (RPSGB). In the longer term, however, the two societies should amalgamate into a single UK body, following the passage of the necessary primary legislation. At the same time any necessary changes can be made to clarify the separation of the RPSGB’s regulatory and professional lead functions. However there should be no other changes to the number of regulators at present. (chapter 7)
25. We will keep under review the question of whether harmonisation of the work done by the remaining regulators delivers the necessary benefits or whether this requires a further cut in the number of regulatory bodies. We will review the position after five years, in 2011. It may be that in practice the need for further structural change can be avoided by closer collaboration and harmonisation between all the remaining regulatory bodies. (chapter 7)