Council – 10 December 2008

Draft Discussion Paper on Extending Professional Regulation

Executive summary and recommendations

Introduction
The Discussion Paper outlines the position of the Health Professions Council on:

- The existing process to statutory regulate new professions
- Extending regulation to Occupational Groups within the healthcare delivery system who are not professionals

The paper outlines the position of the Council on these topics and in particular identifies five key themes. They are as follows:

I. **Article 3 (17) of the Health Professions Order 2001 is used by the Health Professions Council to recommend to the Secretary of State that Aspirant Groups could be statutory regulated is fit for purpose.**

II. **The criteria, guidance and process used by the HPC to formulate their recommendations to the Secretary of State on the possible professional statutory regulation of Aspirant Groups should continue to be revised and adapted in the light of experience.**

III. **Occupational Groups could be regulated using similar processes to those used for the statutory regulation of professionals when education and training programmes can be approved by the regulator.**

IV. **The statutory regulation of Occupational Groups by licensing could be considered where entry to the register is set by examination.**

V. **The ability of Registrants to extend their scope of practise without formally demonstrating to the regulator their competence by way of approved education and training programmes could be limited at the point that risk to patients is unacceptable.**

Decision

1 The Council is requested to approve the Discussion Paper

Background information

None

Resource implications

Not assessed

Financial implications

Not quantified

Appendices

None

Date of paper

30 November 2008

Extending Professional Regulation

Health Professions Council

Draft Discussion Paper

Contents

Introduction
This Discussion Paper outlines the position of the Health Professions Council on:

- The existing process to statutory regulate new professions

- Extending regulation to Occupational Groups within the healthcare delivery system who are not professionals

The paper identifies key factors that have a significant bearing on these issues. They are as follows:

i. **Article 3 (17) of the Health Professions Order 2001 is used by the Health Professions Council to recommend to the Secretary of State that aspirant groups could be statutory regulated is fit for purpose.**

ii. **The criteria, guidance and process used by the HPC to formulate their recommendations to the Secretary of State on the possible professional statutory regulation of Aspirant Groups could continue to be revised and adapted in the light of experience.**

iii. **Occupational Groups could be regulated using similar processes to those used for the statutory regulation of professionals when education and training programmes can be approved by the regulator.**

iv. **The statutory regulation of Occupational Groups by licensing could be considered where entry to the register is set by examination.**

v. **The ability of Registrants to extend their scope of practise without formally demonstrating to the regulator their competence by way of approved education and training programmes could be limited at the point that risk to patients is unacceptable.**

Building blocks of regulation, the Register, standards and processes
All regulators of professionals require an up-to-date and accurate register of specific individuals who meet certain standards and if those standards are not met they are removed from the register. Behind each of the standards is a corresponding process. They are as follows:

i.	Standards of Education and Training	Approval of programmes
ii.	Standards of Proficiency	Registration
iii.	Standards of Continuing Profession Development	CPD assessment
iv.	Standards of Conduct, Performance and Ethics	Fitness to Practise

It will be seen in the following Discussion Paper that the number of professions that are statutory regulated has steadily increased in the UK over the last 150 years. The process used to decide if a Profession or **Aspirant Group** should be statutory regulated is tried and tested. However, the health care delivery system is increasingly reliant on a significant number of individuals who are not professionals and are not statutory regulated. Should these **Occupation Groups** be statutory regulated and if the answer to this

question is yes, how should this be achieved? Also, are they a single amorphous group or, as this Discussion Paper argues, made up of two distinct groups that could be regulated using different processes? Lastly, the regulation of Professionals and Occupation Groups does not end at the point they become registered. The paper therefore concludes by examining a range of options for post-registration statutory regulation.

This Discussion Paper is divided into six parts. They are as follows:

Part One	Statutory regulation of Professionals
Part Two	The challenges of professional statutory regulation
Part Three	Statutory regulation of Assistants
Part Four	Licensing of Healthcare Practitioners
Part Five	Licensing business model
Part Six	Post registration regulation

Before examining these six areas, four other issues need to be addressed. They are as follows:

Public protection
It must be strongly emphasised that the overriding objective of statutory regulation is public protection, although numerous other benefits arise from this objective.

Devolution
The regulation of new professions and Occupational Groups is a devolved responsibility and references in this paper to the Department of Health embrace the Departments of Health in Belfast, Edinburgh and London.

Independence
It is worth noting that it is now the norm in the UK and many other countries that regulators of professionals are independent of government and professional bodies. In this way the regulator can avoid pressure from professional bodies to set standards that are too high and also avoid pressure by employers to reduce standards to an unacceptable level.

Patients, clients and service users
Lastly, the term **patient** is used throughout this paper. However, it is important to note that **client** or **service user** may be more applicable in certain circumstances.

Part One – Statutory regulation of professionals

Introduction

A brief review of the history of the regulation of healthcare professionals across the globe will identify a similar sequence of the order that professions are brought into statutory regulation. Starting with doctors, the professions of nursing, pharmacists, dentistry, allied health professionals and, in a few examples, Complimentary and Alternative Medicine (CAM) practitioners have become regulated. The process to introduce the regulation of new professions is very slow. In the UK it has taken 150 years to progress from the regulation of doctors in 1855 to the regulation of Operating Department Practitioners in 2005.

Process to regulate an Aspirant Group

Of the nine UK regulators of health professionals, the Health Professions Council (HPC) has a unique legal responsibility which enables it to make recommendations to the Secretary of State for Health about the regulation of new professions.

Article 3 (17) of the Health Professions Order 2001 states:

"(17) The Council may-

(a) make recommendations to the Secretary of State concerning any profession which in its opinion should be regulated pursuant to section 60 (1) (b) of the Health Act; and

(b) give such guidance as it sees fit, to such persons as seems to it to have an interest in such regulation, on the criteria to be taken into account in determining whether a profession should be regulated."

The process to regulate a new profession, or Aspirant Group, requires both the HPC and the Department of Health (DH) to undertake specific tasks.

The expertise of the HPC lies in the practical delivery of statutory regulation of healthcare professionals based on a thorough understanding of issues such as standards of proficiency and rules. The DH regulatory team expertise lies in the formulation of policy and the subsequent amendments to primary and secondary legislation.

In essence, the HPC, before making a recommendation to the Secretary of State to regulate a new profession, completes a package of research, standards, processes and legislative rules and consults on them. This then allows the DH regulatory team to concentrate on policy and amendments to relevant legislation.

The existing process is as follows:

[HPC = Black *DH = Blue italic*]

First:

- Initial discussions with Aspirant Group including risk review

- Either reviews an application from an Aspirant Group or instigates a review, using the ten HPC criteria

HPC's ten criteria
Aspirant Groups must:

i. Cover a discrete area of activity displaying some homogeneity

ii. Apply a defined body of knowledge

iii. Practise based on evidence of efficacy

iv. Have at least one established professional body which accounts for a significant proportion of that occupational group

v. Operate a voluntary register

vi. Have defined routes of entry to the profession

vii. Have independently assessed entry qualifications

viii. Have standards in relation to conduct, performance and ethics

ix. Have fitness to practise procedures to enforce those standards

x. Be committed to continuous professional development

The criteria in effect identify the elements required for successful professional statutory regulation. The closer the Aspirant Group is to fulfilling the criteria the greater the likelihood that it will be recommended for regulation. It should be noted that the criteria are not weighted and the HPC sets no minimum requirement on the number of criteria to be achieved.

- Council approves Aspirant Group application in principle and agrees outline timetable

Second:
- Undertakes research including, if appropriate, establishing a Professional Liaison Group (PLG)

- Estimates the number of grandparenting applications, the number of registrants on the day the register is opened and identifies existing education establishments and qualifications awarded

- Identifies those organisations whose members will transfer to the HPC register

- Investigates the duration of the transitional provisions (the length in years of the grandparenting window)

Third:
Seeks the approval of the Council and appropriate Committee(s) on the following:

- The draft Standard of Proficiency for the Aspirant Group
- The draft Standard of Education and Training for the Aspirant Group
- The proposed protected title(s)
- The structure of the register
- Draft Regulatory Impact Assessment
- Draft outline of the probable changes to the Health Professions Order 2001 by Section 60
- The grandparenting arrangements
- The draft rules
- The draft consultation document and timetable on standards, grandparenting and rules
- Consults and publishes the report on the response to the consultation and the final recommendations

Fourth:

- Makes a recommendation to the Secretary of State

Fifth:

- *DH decides policy informed in part by HPC's recommendations*
- *DH consults on changes to legislation*
- *Organises Parliamentary approval*

- Opens the register

HPC's experience to date

To date the HPC has made the following recommendations:

Aspirant Group	Date of decision	Date Register opened
Operating Department Practitioners	2 April 2003	October 2004
Applied Psychologists	4 June 2003	-
Clinical Perfusion Scientists	17 September 2003	-
Clinical Physiologists	8 October 2003	-
Dance Movement Therapists	2 March 2004	-
Clinical Technologists	13 May 2004	-
Medical Illustrators	14 September 2004	-
Maxillofacial Prosthetists and Technologists	13 September 2005	-

Sports Therapists	11 May 2006	-

Imposed versus sought regulation
It should be noted that to date the HPC has only made recommendations about Aspirant Groups who have actively sought statutory regulation. However, the HPC may make a recommendation without the Aspirant Group seeking regulation.

Review of criteria
The ten criteria used by the HPC were reviewed in 2007 and the HPC's Policy and Standards Department will be reviewing them in 2009/10.

Length of processes
It should be noted that the process is slow and that there is a considerable delay between the HPC making a recommendation to the Secretary of State and the opening of the register. The reason for this is due in part to the time it takes for Statutory Instruments to be amended by Section 60s and the number of amendments to the legislation of the nine UK statutory regulators of healthcare professionals following the White paper in response to the Shipman enquiry.

Conclusion

i. **Article 3 (17) of the Health Professions Order 2001 is used by the Health Professions Council to recommend to the Secretary of State that Aspirant Groups could be statutory regulated is fit for purpose.**

ii. **The criteria, guidance and process used by the HPC to formulate their recommendations to the Secretary of State on the possible professional statutory regulation of Aspirant Groups could continue to be revised and adapted in the light of experience.**

Part Two – The challenges of professional statutory regulation

As noted in the preceding pages the time it takes for an Aspirant Group to gain statutory regulation is very long, in many cases taking years or decades. Why is this?

Aspirant Groups - Challenges
The major challenge to some Aspirant Groups is that currently they may only meet some, but not all, of the ten criteria used by the HPC. In particular they may not have:

- A single professional body representing the majority of practitioners
- An agreed set of proficiencies
- A uniform method of education and training
- A single and independently quality assessed qualification
- Limited consensus on the titles to be protected

In addition, the number of trained practitioners may be small and/or some of the members of the Aspirant Group may already be statutorily regulated.

This means that it may be many years before they are in a position to seek statutory regulation. As Government does not provide financial support to Aspirant Groups, professional bodies seeking regulation often find the process to be financially burdensome and frustrating. The process is characterised by long periods of apparent inactivity interspaced by periods of intense and resource hungry activity. This process occurs not only in the UK but also in and other parts of the world.

The future
Assuming that there are no significant changes to the existing process the Aspirant Groups are likely to become statutory regulated in two waves. They are as follows:

1 Likely to be regulated in the short term by 2011, for example practitioner psychologists and hearing aid dispensers

2 Regulated post 2011 – for example various healthcare scientists and counsellors and psychologists

Non-professionals or Occupational Groups - Challenges
The number of individuals in this second group is growing rapidly as the propensity to delegate to individuals who are not professionals in their range of skills is increasing. The occupations they undertake are numerous and their job titles run into the hundreds. In the UK there may be hundreds of thousands of individuals working in the healthcare delivery system that to some extent may be using the techniques and processes that were once the preserve of professionals.

If this group was statutory regulated it would ensure:

- Increased public protection

- Match public expectations

- Enhance professionals' confidence in either working with, or delegating tasks to, other occupations

- Match the UK system of regulating the social care professionals and assistants

- Recognise the role of an important group of workers in the healthcare delivery system

- Prevent struck off professionals working as non-professionals in the care environment. For example if the GMC erases a psychiatrist from their register, they can currently practise as a psychologist, or a psychotherapist or a counsellor.

Unfortunately, this second group who are seeking, or may seek, statutory regulation are even more challenged because the existing process is designed to regulate professionals.

It is therefore reasonable to assume that they will never achieve the majority of the ten criteria used by the HPC.

Why not use professional statutory regulation?
Why will the second group not achieve professional statutory regulation? There a number of reasons. They are as follows:

i. Titles
ii. Standards of proficiency
iii. Approval of programmes of education and training
iv. Initial registration and renewal
v. Cost of professional statutory regulation

Titles
There are several hundred titles used. Protecting the plethora of titles, some of which are very similar, will be problematic and will not prevent individuals who are determined to avoid regulation from inventing and using more titles. For example, someone who does not want to be regulated and works in the chiropody arena can call themselves a "foot healthcare practitioner". If this title was to be protected, they can call themselves a "toe doctor". If, in turn, this title was protected they could call themselves a "complementary foot care adviser", and so on and so forth. The public will not therefore be able to easily recognise those who are regulated from those who are not.

Standards of proficiency
The Standards of Proficiency trigger two problems. Firstly, even if all the different types of occupations and job titles can be grouped together dozens of Standards of Proficiency will have to be devised to reflect all the different occupations. Secondly, the numerous Standards of Proficiency will hinder flexibility in the workforce. Lastly, they could take many years to develop.

Approval of programmes of Education and Training
The type of training and/or education that is undertaken by both groups is expansive ranging from NVQs, diplomas delivered by education providers such as Higher Education Institutes (HEIs) at one end of the spectrum, to minimal on the job training at the other.

Initial registration and renewal
In many cases, there are no voluntary registers. Therefore it would not be possible to open registers in the short term.

Cost of professional statutory regulation
Professional statutory regulation is expensive to operate for the professionals, the taxpayer and other organisations such as HEIs.

In the UK regulated professionals, or registrants, have to fund the regulator without ongoing financial support from the taxpayer. It should be noted that the taxpayer indirectly funds part of the costs of regulation because annual fees are partly tax deductible and costs will be passed on to patients.

The annual registration fee that has to be paid by the professionals of the nine UK regulators of healthcare professionals varies enormously. Currently the most expensive is the General Osteopathic Council (GOsC) with an annual fee of £1,000. The lowest is the HPC at £72.

Statutory professional regulation also imposes costs on other organisations. For example, HEIs must spend time and resources demonstrating that they meet the education standards imposed on them by the regulator.

Statutory professional regulation assumes the existence of at least one professional body. As these are voluntary membership organisations that receive no direct financial support from the taxpayer, the regulated professionals themselves must fund the start up cost and ongoing cost of the professional bodies.

Lastly, there are the indirect costs that have to be funded, for example the economic cost of foregoing employment during the period of education and training that may last many years.

Because the potential registrants below the level of professionals may in some cases be at the lower end of the economic scale in terms of income, equivalent cost structures associated with professional regulation will not be acceptable to individuals, Trade Unions, employers and government.

An alternative system of statutory professional regulation is therefore required if public protection is to be enhanced. What options are there?

Alternative options to professional statutory regulation
There are five alternatives to professional statutory regulation. They are as follows:

1 Maintain existing arrangements
This is the current situation, where only professionals are regulated by statute. It is not acceptable because of:

- Lack of public protection
- Glaring inconsistency compared with social workers

2 Voluntary non-statutory regulation
One option is to set up a voluntary register (or registers). They would be voluntary in that there would be no compulsion to join the register and there would be no protected titles. The registers could be maintained by a non-governmental organisation such as a professional body or a government funded organisation such as a consortium of NHS Trusts. In the future, professional bodies could apply to the Privy Council for chartered status and this would lead to protection of the chartered title. While some would join the register the public would continue to be unprotected from rogues and charlatans in that they would not be able to easily identify who was on the register and who was not.

Regulation without the force of statute will not deliver appropriate public protection.

While not an ideal solution, in that if offers little public protection, it is at least a better option than no regulation whatsoever. In effect this is the first stage of the process leading to statutory regulation of professionals and is a well-trodden route. It is therefore interesting to note that various complementary occupations have recently announced the establishment of just such a register, the Complementary and Natural Healthcare Council (see www.cnhc.org.uk).

3 Employer led regulation
An option that is currently being investigated in Scotland by way of a pilot project is to achieve regulation on a voluntary basis by allowing employers to establish employment criteria but without establishing registers of suitable individuals.

The challenges this process has identified are as follows:

- How should the process be funded?
- Who would set and maintain standards?
- How will information and intelligence be exchanged?
- There are minimal economies of scale and the process may be expensive to maintain
- The employers are not independent of government and standards may not necessarily to deliver proper public protection
- Excludes individuals who are not employees

Lastly, because the process is voluntary a central register cannot be maintained. If there was a register, then a process would have to establish to set the standards to gain entry to the register and likewise, a process would need to be established to remove individuals from the register if those standards were not maintained.

4 Non-professional statutory regulation

Under this arrangement, statutory regulation would be introduced but the criteria for regulation would be amended on the assumption that the Aspirant Groups are not professionals.

The target cohort of individuals would be those who attend an education/training programme which can be approved by a regulator. This cohort will be referred to as **Assistants.**

5 Voluntary non-professional statutory regulation using licensing

Under this arrangement, statutory regulation would establish and protect a title. However, the system would be voluntary in that there could be no compulsion to use the title.

The cohort of individuals would be identified in that their education/training would not be approved by the regulator. This cohort will be referred to as **Licensed Healthcare Practitioners**.

The following three parts of this Discussion Paper explore the last two options in more detail.

Part Three - Statutory regulation of Assistants

Introduction

In all respect the system of regulation would be identical to existing professional statutory regulation except for two components. They are as follows:

Standards of proficiency

The standards of proficiency would be the same as the corresponding professional except that they could only be undertaken by Assistants if they were supervised.

Titles

The Protected title would be **Assistant XXXX**, where XXXX represented a corresponding protected professional title.

For example:

Assist Physiotherapist
Assistant Nurse

In all other respects the process used to regulate Assistants would be the same. Thus, for example, the programmes of education would be approved by the regulator. If the system was managed by an existing regulator there would have to be appropriate changes to governance arrangements.

Conclusion

i. **Occupational Groups could be regulated using similar processes used for the statutory regulation of professionals when education and training programmes can be approved by the regulator.**

Part Four - Licensing Healthcare Practitioners

Introduction

The introduction of the statutory regulation of assistants would not address those individuals who do not receive lengthy education and training before gaining employment in the healthcare delivery system.

A possible solution would be for those individuals to be licensed and then be entitled to use a single protected title ***Licensed Healthcare Practitioner***. No other titles would be protected. By protecting a single title rather than the hundreds in daily use the public would more easily recognise those they can have confidence in. Licensing would not be compulsory but would be voluntary and with the lead of large key employers, would become part of standard conditions of employment. In the medium term the regulator would commence a communications campaign encouraging the public to only be treated by those who are Professionals, Assistants or Licensed Healthcare Practitioners.

Individuals would join the register after passing a practical test that would normally be achieved after the equivalent of four to six weeks full-time training. Part-time and on-the-job training would be strongly encouraged to minimise costs. The test would be held frequently each year in numerous facilities and the cost of taking the test would be minimal. When the register opens there would be no requirement for a "Grandparenting" process, thus minimising costs. Training programmes would not be individually approved by the regulator. Training programmes would be organised by many different types of organisations including: SHAs, HEIs, Trade Unions and commercial providers. International applicants, including those from the EU, would be able to join the register after passing the test.

There would be a single straightforward Standard of Conduct, Performance and Ethics for all licensees. The Standards of Training would focus on issues such as: communication, confidentiality, delegation of tasks, infection control, patient rights, record keeping and team working.

Registrants who fail to maintain standards would have their licence revoked. Tribunals are forecasted to be required at a rate in line with professional regulators, of 1.8 per thousand licensees. If licensees wish to be reinstated, their appeals would be heard in the Magistrates' Courts.

Once the register opened, the regulatory system would be self-funding and would be designed to be affordable to healthcare workers whose salaries can be significantly lower than those of healthcare professionals. The annual £30 registration would be payable in two instalments and be tax deductible, thus amounting to £2 per month for basic rate taxpayers. Regulation must not be burdensome.

The existence of a licensing system would not preclude aspirant groups from seeking and achieving statutory regulation but would facilitate the transition process

Relationship between professional and licensing regulation
The introduction of licensing would not stop, or hinder, the process whereby an Aspirant Group sought to become a statutorily regulated profession. It can be argued that licensing would indeed facilitate the process, in that an Aspirant Group that was already licensed will more easily be able to demonstrate that many of the prerequisites for statutory regulation have been met.

Who to license
Licensees would come from a number of sources, including:

- Employees of the NHS in England, Northern Ireland, Scotland and Wales
- Agency workers
- Independent practitioners
- The voluntary sector

Estimate of number of licensees
There is no definitive source on the number of potential licensees. However, numbers could be in the hundreds of thousands.

Forecast of the rate of growth of licensee numbers
Individual licensees would initially come from three sources:

i. Large employers would make the holding of a licence a condition of employment for specific jobs.

ii. This would also be a requirement of any agency workers employed.

iii. Individuals may decide to voluntarily join the register. Examples would include private practitioners for example foot healthcare practitioners.

It is assumed that the number of licensees would increase at a modest rate until significant and large employers made the holding of a licence a condition of employment.

After a reasonable period of time, say three years, the regulator would start an intense communications exercise to inform the public to check to ensure that they were being treated by Licensed Healthcare Practitioners, Assistants or Professionals. The regulator would work with advertising media for example Yellow Pages to ensure the correct identification of license healthcare practitioners. It is assumed that this would act as a significant catalyst to increasing licensee numbers.

Protected title
To enhance public protection the public must be able to easily recognise and identify who is statutorily regulated and who is not. Under the system of professional statutory

regulation this is achieved by only allowing those on the register to use a specific title or, "protected" title. Thus only those on the HPC register can use the title Physiotherapist.

The same principle will be used to regulate Licensed Healthcare Practitioners.
It is therefore proposed that only one title is protected. This would be **"Licensed Healthcare Practitioner"**. If the title were used by anyone not entitled to use with the intention to deceive, then they would be committing a criminal offence and could be prosecuted in line with Article 42 of the HPO.

Training standards and guidance
The type of training would not be set down in standards as with the case of regulated healthcare professionals. Limited guidance would be provided for those individuals or organisations running training courses.

Length of training
A system requiring a short period of initial training would be used so that it would not be too onerous on employers and licensees in terms of the direct cost of training and indirect cost such as backfilling. The length of training to become a Licensed Healthcare Practitioner would not be fixed in terms of a prescribed number of hours or days of training. It is assumed that the typical time it would take to acquire enough knowledge and skills to pass the exam would be about four to six weeks. It is envisaged that the training would also be provided on a part-time basis so that employers and employees could benefit by working at the same time as acquiring the knowledge and skills to pass the exam.

Training providers
There will be no limitations on who can provide training to those seeking to acquire the knowledge and skills to pass the exam to become eligible to apply to become a Licensed Healthcare Practitioner. It is assumed that, over time, a range of providers will be established. They could include:

- Employers
- Trade Unions
- Professional Bodies
- Commercial Training organisations

Training could be provided in a variety of settings including dedicated facilities, evening classes or via the web. The Regulator will not inspect programmes and would not approve courses. A list of training courses directly open to the public would be maintained. However, the Regulator will publish pass rates of training providers. One of the main benefits of the process is that cost will be kept reasonable and thus be affordable to both employers and potential licensees.

Standards – Conduct, performance and ethics
The standards would not be occupation role specific. There will be one set of standards for all licensees. This is in contrast to professional regulation where there are three separate standards, namely: Standards of Proficiency; Standards of Conduct Performance and Ethics and Standards of Education and Training.

For Licensed Healthcare Practitioners standards would primarily focus on conduct and behaviour, rather than competences, for example:

* Health and safety
* Communication
* Patient Confidentiality
* Consent
* Behaviour and conduct
* Duty of care
* First aid
* Team working
* Legal issues
* Document management
* Relationship boundaries
* Delegation
* Antiseptic and sterilisation techniques and infection control

In addition, "Licensed Healthcare Practitioners would be expected to undertake at least one "Controlled Acts" for example:

* Invasive technique
* Handling of patients
* Handling of tissue or blood samples
* Laying of hands on patients
* Manipulation of patients

As with other forms of statutory regulation, the standards should be periodically reviewed and adapted over time.

Test
An individual would be allowed to apply for a licence if they had passed a test.

It is imperative that the test will not dissuade individuals from working as a Licensed Healthcare Practitioner. The test would consist of two components, namely a practical demonstration of competence and a "written" test.

The "written" test could for example consist of 25 multiple-choice questions. It would not be a paper based test but would be taken on line via the internet. The test would be held six or four times a year at numerous test centres throughout the UK. The cost of entering the test would be modest, in the order of £10 - £15 and there would be no restrictions on the number of times an individual could take the test.

High security levels would have to be achieved to ensure that only the correct person sat the test and that cheating opportunities were reduced to an acceptable level. The consequences of cheating would have to be covered in the new legislation.

The regulator would not run tests in the sense of collecting fees, checking the identity of examinees, providing facilities, marking and publishing the results and informing candidates of results. All these services would be provided by external specialist

organisations via contracts. The regulator would be responsible for setting the test questions. It is anticipated that large organisations in terms of the number of employees may set up their own internal system to hold tests probably at the conclusion of an employee Induction Programme. They may be more or less frequent than the “open” system of tests.

Conclusion

i. **The statutory regulation of Occupational Groups by licensing should be considered where entry to the register is set by examination.**

Part Five - Licensing Business Model

Introduction

For a statutory regulator to deliver public protection in an efficient and economical manner it must establish an appropriate business model. An organisation delivering regulation by licensing must likewise be organised from inception to operate processes and systems that are designed to be cost effective. This penultimate part of the Discussion Paper details how this could be achieved.

It is also important to understand in detail how the process of regulation would operate and thus be able to judge its potential effectiveness.

Application process

Applicants will have to complete a licensing application form providing the following personal details:

- Home address and changes of address for the last five years.
- UK National Insurance number.
- Counter signature for photograph likeness including name and contact details and employment.
- Payment method.

Applicants would have to confirm in writing that:

- They were not currently registered with a UK regulator of healthcare professionals for example the NMC or the HPC.
- They work, or intended to work, in the healthcare arena and were in contact with patients or had an influence on patient care.
- They intended to use one of the designated “Acts”.
- They had no relevant health issues, (subject to existing legislation).

Applicants will have to provide:

- Proof of having passed the “Licensed Healthcare Practitioners” test. Passing the test would have to been achieved within a specific period of time, for example within the last two years. The proof would consist of supplying a unique code, which would have to match the electronic pass list from the exam.
- Proof of identity to be confirmed via specific documents such as driving licence or passport.
- Result of a criminal record check.

There would be no separate application fee.

The Licence
The licence will be in the form of a plastic credit card. They will be colour coded to reflect their current validity using a similar process used on car tax discs. The licence will show:

- Name of Licensee
- Colour photograph of the Licensee
- Registration number
- Start and Expiry date of licence
- Contact details of HPC
- Security features

The licence will incorporate a number of security features to assist in preventing counterfeiting. No paper licence certificate will be issued. This will have the advantage of keeping costs to a reasonable level. If the license is lost more than once, a replacement £10 fee will be charged.

Appeals process for rejected applications
Individuals whose application for a licence is rejected by the regulator, will have to have the ability to appeal firstly to the regulator and then secondly, to the Magistrates' Courts.

Length of initial licence
The first licence will be valid for a minimum period of three years and one month, to a maximum period of four years. Thereafter, licences will be issued for a period of four years. This will lead to an even distribution of licence renewals throughout the year. The process will help keep costs lower compared to the regulators of healthcare professionals.

Licence fees
The licence fee must be kept to a reasonable level because the majority of licensees will be unable to afford a high fee. In 2008 terms the annual fee will be £30 per annum or 42% of the cost of the current NMC registration fee.

To deliver a low fee compared to the fees for existing regulators the delivery of the service should be provided by one or more of the existing regulators. This will ensure:

- Limited start up costs
- Sharing of established overhead costs
- Adaptation of existing processes rather than establishing new ones (i.e. IT and fitness to practise systems)
- Less expenditure on approving training providers
- Longer licence renewal cycle
- The use of similar standards and no profession specific partners
- No grandparenting / transitional arrangements
- No fitness to practise appeals to the High Court

- Use of existing and tried and tested legislation
- Lower level of risk in relation to competence as the majority of licensees are supervised
- Capture of economies of scale

Licensees will be encouraged to pay by direct debit twice a year (i.e. £15 once every six months). Those who do not use direct debit will have to pay the annual fee in a single payment. It is assumed that the licence fee will be tax deductible via an application to the Inland Revenue.

Renewal of licences

The licence will expire after a given period of time and all registrants will be required to apply for a new licence. It is proposed that the licence will last for four years.

The new licence will only be issued if confirmation of certain conditions were forthcoming. These would be for example that the Licensee was still working in the healthcare delivery system and was in good health.

With many thousands of potential registrants a solution will be needed to spread the renewal applications over the four-year renewal cycle. This will enable the regulator to have a smaller registration department capacity in terms of systems and FTEs and to avoid peaky demand. It would also have the benefit of keeping costs lower.

To ensure an even distribution over demand throughout the four-year cycle, renewal dates will be allocated alphabetically by surname to a particular month and year. Thus, surnames starting with the letter ”A” would be renewed in January year one, surnames beginning with “L” in December year three, and so on and so-forth.

A, B, C, D, E & F	Year One
G, H, I, J, K & L	Year Two
M, N, O, P, Q, R & S	Year Three
T, U, V, W, X, Y & Z	Year Four

The ability to renew licences will be available from the date the register opened and uptake will be actively encouraged. Again this would lead to lower operating costs.

Opening the register

The register will open on a widely published predetermined day, for example 1st April 2012. There will be no restrictions on which occupations can apply and when.

Communication

A significant amount of time and effort will be allocated to general communications with the overt intention of informing the public and potential registrants about the benefits of licensing and new processes.

There will also be two specific communication campaigns.

Firstly, there will be one before the register opens to ensure that key stakeholders including employers, professional bodies, trade unions and individuals, are aware of the opening of the register.

A second campaign will be implemented a number of years after the register opens. The campaign will inform the public about licensing and recommend that they should ensure that those on a register should only treat them.

Grandparenting

A "grandparenting", or "transitional", process occurs when a profession or occupation becomes regulated and the improper use of any protected title becomes a criminal offence.

On the day the register opens, only those who have gained the appropriate training or qualification can use the protected title. Thus, when Paramedics became a statutory regulated profession, on the day the register opened any prospective registrant had to have successfully completed a Paramedic training courses which was approved by the regulator. However, this would have deprived those who had been working as Paramedics, but had never gained the qualification, from earning their living by practising their chosen vocation. This is unlawful under UK legislation. To avoid this situation, the "grandparenting " process allows those who can demonstrate that they have used the title over a set period of time before the register was opened and that they have practised safely, effectively and lawfully, to apply to join the register even though they do not have the prerequisite qualification.

The grandparenting process is very expensive to manage. However, since no one is currently using the title "Licensed Healthcare Professional" its protection will not deprive anyone of his or her livelihood.

Also, registration will not be imposed by statute but would be voluntary. This would mean that a grandparenting or transitional process will not be required since the opening of the register would not deprive anyone of their living. There will also be no transfer of voluntary registers to the new register. This would lead to reduced start-up costs.

International applicants

All international applicants will have to pass the licensing exam to join the register. However, the processes will have to reflect EU Directive arrangements. There will be no additional international application fee.

EU Competent Authority

The regulation will become the UK's EU Competent Authority. The system of temporary and occasion registration recently established by the new Directive 26/2008 will have to be established.

Fitness to practise

A cost effective method will be used to decide if individuals should lose their licence due to unacceptable standards of conduct, performance or ethics and/or health.

It is assumed that the number of allegations per thousand registrants will be similar to those that are received by the HPC (i.e. 1.8 in 1,000). The system used by the HPC will be used. This embraces civil standards, the use of partners, legal assessors and the presentations of cases by non-legally qualified employees.

However, the number of partners will be significantly lower as there will only be one part of the register.

It is anticipated that, given the more limited scope of practise, allegations relating to competences will be more formulaic. It is assumed that fewer licensees will attend Tribunals with legal representatives compared to professional fitness to practise tribunals of the existing nine regulators.

Fitness to practise appeals
Licensees will be able to appeal to the Magistrates' Courts in England and Wales and equivalent bodies in Northern Ireland and Scotland if they believe that a fitness to practise tribunal has made the wrong decision.

In the short term, it is assumed that CHRE will have intervention powers against too lenient decisions of the licensing tribunals.

Bichard and Barring lists
The register would be linked into the Bichard system in England and Scotland whereby a registered occupation working with vulnerable adults and children would be able to be included in the scheme. This would lead to an enhanced reduction of risk afforded to the public as is available in professional statutory regulation.

Validation
Although in the long term there may be justification for its introduction, compulsory and demonstrable Continuing Professional Development (CPD) and revalidation would not be a prerequisite to re-licensing in the short term. There would be no reason why CPD would not be provided by employers and others.

Governance arrangements
The regulator(s) would change their governance arrangements to accommodate the statutory regulation of Licensed Healthcare Practitioners.

Two key areas of change would be required:

Firstly, the establishment of a Statutory Committee to deal with specific issues relating to Licensed Healthcare Practitioners. It is assumed that the Chair of the Council will be the Chair of the Committee. Other committee members would be drawn from Council members or will be recruited for their respective expertise.

Establishing the licensing register
There are three options as to where the operation of the new register and associated functions could be located. They are as follows:

Either,

I Create a totally new regulator.

Or,

Ii Expand the role of one of the existing nine regulators.

Or,

Iii Expand the role of more than one of the existing nine regulators.

Should there be more than one register? There are clear benefits for one register:

- Single standards
- Minimises duplication of effort
- Gains of economies of scale
- Avoids multiple legislation to approve and maintain
- Prevents possible lack of consistency of approach

It is assumed that this decision should be based on economic considerations alone.

Costs of establishing a licensing register
By using an established regulator to commence the regulation of Licensed Healthcare Practitioners, any start-up costs would be significantly lower compared to establishing a new organisation.

It would be unreasonable for existing registrants to fund the costs of establishing a part of the register for Licensed Healthcare Practitioners and it is therefore assumed that a grant would be made to the regulator by the Department of Health (DH) using similar arrangements that are set out in Article 45 of Health Professions Order 2001.

Part Six – Post-registration regulation

Post-registration regulation

The Discussion Paper has reviewed the way in which the HPC statutory regulates professions, how new professions are brought into statutory regulation and how statutory regulation could be extended to non-professional occupational groups such as Assistants and Licensed Healthcare Practitioners. These processes deal with initial regulation at the initial point in time that individuals join the register. What regulatory processes are there to ensure that registrants remain competent following registration?

There are three options.

Re-registration

Registrants can be required to periodically renew their registration and self-declare that they continue to meet defined standards, for example health, conduct and proficiency.

Continuing Professional Development (CPD)

Registrants can be required periodically to demonstrate that they have undertaken defined activities to enable them to better treat patients in the future. Continuing Professional Development (CPD) is the process to achieve this. The process can be linked to re-registration.

Revalidation

Registrants can be required periodically to demonstrate that they meet standards of proficiency at any point in their careers following registration. This can range from initial registration standards to those gained later in their careers. Revalidation is the term to describe the process and again, the process can be linked to re-registration.

Lastly, it should be noted that the regulator's fitness to practise process, will also play a role in ensuring that registrants meet expected standards once they join they register.

Extended scope of practise

In parallel with processes to enable registrants to demonstrate their ability to meet threshold standards, it is assumed that they can extended their scope of practise within certain constraints, yet at the same time remain on the register without the need to demonstrate to the regulator by way of examination and testing that they are competent in a new area.

For example, a new technique may be introduced that was not part of the scope of practice when a registrant joined the register. By undertaking appropriate training and supervised practise the new set of additional competences can be acquired.

Because of the use of this principle, the need for constant formal testing is not required and is not observed in the UK.

Regulatory intervention and extended scope of practise
However, is there a point where regulator intervention is required before an individual is allowed to extend their scope of practise? The answer is yes. The challenge is where.

If the intervention level is set too low, registrants may accumulate qualifications for every conceivable area of practice. If the level is set too high, the public will not be adequately protected as registrants may undertake practice without the appropriate training and resulting competences.

In addition, the more registrants are restrained on extending their scope of practise, the more inflexible the workforce will become. The regulator therefore has to balance appropriate levels of public protection versus maintaining an economic and flexible workforce.

Post-registration training
Article 19 (6) of the Health Professions Order 2001 makes specific reference to post registration training. It states:

"In respect of additional qualifications which may be recorded on the register the Council may establish standards of education and training ....."

Thus, the HPC has established that professionals who want to acquire the right to prescribe medicines must complete an approved programme of education.

There may be pressure on the regulator to approve numerous types of post-registration training. However, as the purpose of the process is to protected it is reasonable to assume that regulators will limit this type of regulation to qualifications on the basis that if the registrant has not gained the qualification then they should be prevented from undertaking the task/practise.

Patient risk

If you have not he qualification then you should not be allowed to do x

Conclusion

i. **The ability of Registrant to extend their scope of practise without formally demonstrating to the regulator their competence by way of approved education and training programmes could be limited at the point that risk to patients is unacceptable.**