Council, 4 December 2014

Department of Health response to HCPC Health Committee report

Executive summary and recommendations

Introduction

The Department of Health has responded to the Health Committee's report of its accountability hearing with the HCPC in January 2014. They have responded to those recommendations made by the Committee which were for the Government and those recommendations which were about the extension of statutory regulation.

The Committee has also formally published the HCPC's response to its recommendations.

Both documents are appended.

Decision

This paper is to note; no decision is required.

Background information

No date has yet been set for when our next accountability hearing will take place.

Resource implications

None

Financial implications

None

Appendices

- Government response to the House of Commons Health Committee Report of Session 2014-2015: accountability hearing with the Health and Care Professions Council.
- Health Committee - Fourth Special Report 2014 accountability hearing with the Health and Care Professions Council: Health and Care Professions Council's Response to the Committee's First Report of Session 2014-15

Date of paper

19 November 2014

Department of Health

Government Response to the House of Commons Health Committee Report of Session 2014-15: accountability hearing with the Health and Care Professions Council

Cm 8916

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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

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Government Response to the House of Commons Health Committee Report of Session 2014-15: 2014 accountability hearing with the Health and Care Professions Council

INTRODUCTION

On 18 June 2014, the House of Commons Health Committee (the Committee) published the report: 2014 *Accountability hearing with the Health and Care Professions Council* (HCPC).

The Department is of the view that such hearings are of great value in strengthening the accountability of the professional regulatory bodies to Parliament and the wider public.

The Department is committed to continuing to work with the HCPC, Devolved Administrations and other stakeholders in developing policy affecting regulation of United Kingdom (UK) health professionals.

DEPARTMENTAL RESPONSE

The Department welcomes this report and we have carefully considered the Committee's recommendations and the issues it raises.

The majority of the report's recommendations are for the HCPC. This paper sets out the Government's response to the two recommendations (recommendations eight and nine) directed to the Department of Health but also provides a response to comments made in recommendations seven, eleven and twelve which may be of interest to the Committee. Our response is divided into three areas: assurance of social care workers; DH secondary legislation programme during this Parliamentary session; and statutory regulation of other new groups.

Assurance of social care workers

Recommendation Eight: The Committee is concerned by the most recent in a series of reports of abuse by social care workers. In 2011, the Government proposed a voluntary register, but no progress has been made since then and we agree with the HCPC that in any event voluntary registration would not be effective. We recommend that, as a first step to improve regulation in this sector, the Government should publish plans for the implementation of the HCPC's proposals for a negative register. The legislation that would be required to enable the establishment of such a negative register is contained in the Law Commission's draft Bill on the regulation of health and social care professions. Beyond the establishment of a negative register, we recommend that the Government, working with the PSA and the HCPC, develop further proposals for more effective regulation to provide proper safeguards in this area. (Paragraph 54)

The Government agrees that any abuse by social care workers is unacceptable and that effective standards for all care workers (health and social care) are critical to delivering safe high quality care for patients.

However, regulation is not a panacea and must be proportionate to the potential risk

of patient harm. Social care workers are subject to pre-employment scrutiny as well as training and competency requirements by their employers.

In support of this, Skills for Health and Skills for Care were commissioned to develop National Minimum Training Standards and a Code of Conduct for health care assistants and social care workers in England. These were published in March 2013 and are now being developed further, as part of the work programme following on from the independent Cavendish Report published in July 2013.

Health Education England (HEE), in partnership with Skills for Care and Skills for Health, has developed a draft set of standards for the Care Certificate, which is currently being piloted across a range of employers spanning health and social care. The Care Certificate will introduce clear evidence to employers and patients that the health or social care worker caring for them has been trained and developed to a specific set of standards. The Care Certificate ensures that the healthcare worker has been assessed for the skills, knowledge and behaviours to ensure they provide compassionate, high quality care and support. Subject to evaluation, the Care Certificate will be rolled out to newly-employed healthcare assistants and social care support workers from April 2015 and require support workers to hold the Certificate before working unsupervised.

HEE and Skills for Health are also working with the Care Quality Commission (CQC) to ensure Care Certificate documentation sets out how newly appointed healthcare assistants and social care support workers should not be allowed to work unsupervised until they have proven their competence through attainment of the Care Certificate.

CQC registration requirements state that all providers of regulated activities must ensure that they have the right staff with the right skills, qualifications, and experience to undertake the tasks to be performed. Where providers fail to comply, the CQC has a range of enforcement powers.

HEE, through their mandate, are required to oversee delivery of a national values based recruitment framework and associated tools and resources by October 2014, which will support employers to test values, attitude and aptitude for caring during recruitment.

In addition to this, the Department has made a number of changes to improve the regulation of providers of adult social care. This includes increasing the effectiveness of the CQC through the introduction of specialist inspection teams headed by the Chief Inspector of Adult Social Care, the development of a special measures regime for social care providers, and the development of a “fit and proper persons test” for Directors of NHS and social care providers. These measures will make providers more accountable for the quality of care that they deliver, and will mean that individual carers are working in an environment that is subject to more rigorous scrutiny.

This builds on existing processes such as supervision of unregulated staff by regulated professionals, and the Disclosure and Barring Service.

Additionally, in April of this year, the Law Commission published its report and draft Bill on the regulation of health and social care professionals. The idea of a negative register as suggested by the HCPC is, as the Committee is aware, one of the Law Commission’s recommendations.

Update on Department of Health proposals to amend the powers of the regulatory bodies by secondary legislation during this session of Parliament

Recommendation Nine: We ask the Department of Health to set out in response to this report what changes it proposes to make to the powers of regulatory bodies by secondary legislation during this session of Parliament, and when it anticipates that they will be brought forward. (Paragraph 55)

Ahead of the publication of the Government's response to the Law Commission Report, the Department of Health is already committed to taking forward work to consult on:

- the statutory regulation of Non-Medical Public Health Specialists by the HCPC;
- putting in place the framework and mechanism to strengthen the Professional Standards Authority's independence of Government by being able to raise fees from the bodies it oversees.

The Department has also consulted on amendments which will give the Nursing and Midwifery Council powers to carry out its fitness to practise and registration functions more effectively – we intend to lay the Order in October. We are also developing measures which will help the General Dental Council to speed up the early investigation stages of the fitness to practise process, providing more efficient, effective and proportionate regulation; as well as launching a consultation on 31 July on proposals to modernise and reform the General Medical Council's (GMC) adjudication of fitness to practise cases. We are working towards these measures being in place in this Parliament. The Department also intends to legislate to give regulators the power to introduce proportionate language controls for nurses, midwives, dentists and pharmacists from the European Economic Area. The GMC were given this power earlier this year, and, subject to parliamentary processes, are working towards laying the Order before May 2015.

Statutory Regulation of Other Groups

Recommendation 11: In addition to this, since 2003, the HCPC has recommended to Government that statutory regulation be extended to eleven other professions. Of these, the only groups to receive statutory regulation to date are operating department practitioners and practitioner psychologists. Statutory regulation gives professions, in the words of the HCPC, "a huge badge of respectability, professionalism and endorsement." Decisions about whether to extend statutory regulation to different professions need to be informed both by considerations of issues of patient safety, and consideration of the evidence base for that profession. We do not seek to make judgements on either of these factors for individual professions, and, although as the HCPC has pointed out that health and care regulation is not currently "a very logical landscape", at this stage we are not seeking to make recommendations for change simply to address inconsistencies. However, if there are unregulated groups which need to be regulated on the grounds of patient safety, this should be dealt with swiftly. (Paragraph 73)

Recommendation 12: We received written evidence from the Registration Council of Clinical Physiologists arguing strongly that Clinical Physiologists should be subject to statutory regulation, a position that the HCPC agreed with. We recommend that, in responding to this report, the HCPC lists any professional groups for which they feel there is a compelling patient safety case for statutory regulation

so that we can take this further with the Department of Health as a matter of urgency. We are concerned at the length of time it can take for professional groups to gain statutory regulation. As we understand that new groups can be added to the HCPC's register by means of secondary legislation we see no reason why there should be undue delay in extending statutory regulation to professional groups where there is a compelling patient safety case for doing so. (Paragraph 74)

The recommendations made by the HCPC to Government were between the period 2003 and 2011, with the majority of these being made in the early part of this period. This reflects Government policy at the time which in the light of the Shipman, Ayling, Neale and Kerr/Haslam inquiries was to encourage statutory regulation as the way of ensuring public protection. Towards the end of the previous administration this approach was being refined with the PSA (formerly known as the Council for Healthcare Regulatory Excellence or CHRE) publishing its 'Right-Touch Regulation' Paper in August 2010; and the Report of the Working Group on Extending Professional Regulation in 2009; both indicating that decisions to regulate new groups should be made after a "risk-based assessment"

Whilst this Government agrees there is a clear need to assure public safety by ensuring the quality of care by individual healthcare professionals, the Command Paper 'Enabling Excellence' (February 2011), set out the Government's vision for the future of professional regulation. The paper recognises that while statutory regulation is sometimes necessary, it should not be the default position. Rather, where significant risks to users of services cannot be mitigated in other ways, the extension of the current statutory regulation framework will only be considered where there is a compelling case on the basis of a public safety risk and where assured voluntary registers are not considered sufficient to manage this risk.

As detailed earlier in this response, the assurance of an individual practitioner needs to be seen in the context of the evolving system of regulation and the duties of an employer to ensure they have the right person with the rights skills, training and experience to provide patient and service-user focused treatment and care.

In focusing on recommendations made up to eleven years ago, there is a clear possibility that the context to these will have moved on. For example; within the recommended groups are professionals who will fall under the umbrella title of healthcare scientists. These are:

- Clinical Perfusionists;
- Clinical Physiologists;
- Clinical Technologists;
- Medical Illustrators;
- Maxillofacial Prosthetists.

Since 2010, Modernising Scientific Careers has put in place standardised and accredited education and training programmes for the health care science work force that enables formalised regulation, whether voluntary or statutory.

For those health care scientists not regulated by statute, the Academy for Healthcare Science holds a voluntary register and will be seeking accreditation from the PSA. This is assurance that is appropriate and proportionate to the risks presented to public safety.

The DH notes the HCPC's assertion that statutory regulation gives professions "a huge badge of respectability, professionalism

and endorsement". We consider that this statement does not reflect the purpose of regulation, which is public protection.

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House of Commons
Health Committee

2014 accountability hearing with the Health and Care Professions Council: Health and Care Professions Council's Response to the Committee's First Report of Session 2014–15

Fourth Special Report of Session 2014–15

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The Committee Name

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Dr Sarah Wollaston MP (*Conservative, Totnes*) (Chair)[1]
Rosie Cooper MP (*Labour, West Lancashire*)
Andrew George MP (*Liberal Democrat, St Ives*)
Robert Jenrick MP *(Conservative, Newark)*
Barbara Keeley MP (*Labour, Worsley and Eccles South*)
Charlotte Leslie MP (*Conservative, Bristol North West*)
Grahame M. Morris MP (*Labour, Easington*)
Andrew Percy MP (*Conservative, Brigg and Goole*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and by The Stationery Office by Order of the House.

Evidence relating to this report is published on the Committee's website at www.parliament.uk/healthcom.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Laura Daniels (Committee Specialist), Stephen Aldhouse (Committee Specialist), Daniel Moeller (Senior Committee Assistant), Nathan Hug (Committee Support Assistant), and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 14 Tothill Street, London SW1H 9NB. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk

1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

Fourth Special Report

On 18 June 2014 the Health Committee published its First Report of Session 2014–15, *2014 accountability hearing with the Health and Care Professions Council* (HC 339). The Health and Care Professions Council's response was received on 26 September 2014 and is published as the Appendix to this Special Report.

Appendix – Health and Care Professionals Council response

The Health and Care Professions Council (HCPC) is the independent statutory regulator of 16 health, psychological and social work professions. Our main objective is to safeguard the health and wellbeing of persons using or needing the services of our registrants and we do this by:

- setting and maintaining standards for professional skills and conduct;
- maintaining a register of professionals who meet these standards;
- approving and monitoring education programmes leading to registration; and
- taking action when a registrant's fitness to practise falls below our standards.

The Health Committee published its first accountability report about the HCPC on 18 June 2014. We welcome the Committee's scrutiny of our work. This document sets-out our response to each of the Committee's recommendations.

Fitness to practise

The PSA has highlighted the specific issue of routine health checks for registrants who are convicted of drink or drug related offences. The HCPC has argued that rather than introducing a blanket policy of health checks, a case-by-case approach is more proportionate. We will revisit this issue next year. (Paragraph 20)

We treat cautions and convictions for drink and drug related offences seriously. They will always be investigated thoroughly and a case-by-case decision reached about the action necessary to protect the public.

To date, we have decided against a blanket policy of health assessments in all cases involving drink or drug related offences on the grounds of fairness and proportionality. We have yet to identify any available evidence which suggests conclusively that because a registrant is cautioned or convicted of an offence relating to drink or drugs, that there will be an underlying health condition. It is also possible that if a registrant does have a drink or drug related health condition, they will have taken steps to manage their fitness to practise so that their condition does not impact on their ability to practise safely and effectively.

Further, the HCPC has no existing powers which would allow it to require a registrant to undergo a health assessment as part of an investigation.

We are in the process of commissioning research which will look at the published evidence on this topic and which will inform our continuing position and approach going forward. We would welcome further discussion about our position and approach in this area at our next accountability hearing.

Evidence we received from organisations representing professions registered by the HCPC also raised some specific concerns about the HCPC's fitness to practise processes. We recommend that the HCPC consider the individual points raised in written evidence by these organisations, and provide a response to those organisations, to ensure that their feedback is used, where necessary, to improve processes. (Paragraph 21)

In conjunction with organisations representing professions registered by the HCPC and with trade unions, we have set up the HCPC Fitness to Practise Partnership Forum. The Forum is made up of representatives of our Fitness to Practise Department and representatives of professional bodies, associations and trade unions representing HCPC registrants. The purpose of the Forum is to provide a means to communicate and share a common understanding of issues relating to the fitness to practise process; to provide an arena for dialogue on a range of issues including rules, policies, guidance, practice and procedure relating to the fitness to practise process; and to work in partnership to address specific concerns including those of registrants, complainants and witnesses involved in the fitness to practise process. The Forum seeks to enhance the efficiency, integrity and robustness of the fitness to practise process.

The Forum will meet every six months with the first meeting held in May 2014 and the second meeting due to take place in November 2014. The organisations that provided written evidence to the Committee are members of the Forum and attended the meeting held in May 2014. We have also set up a dedicated email address for representative bodies to send their feedback to us and put in place escalation mechanisms for concerns about cases to be raised.

We asked the HCPC to provide us with further information on the length of time it takes to conclude fitness to practise cases. The HCPC reported to us that in 2012–2013 the average total length of time to close all cases was 9 months; the average length of time to conclude cases that went through a final hearing was 16 months. However, reporting 'average' timescales can conceal wide variations and certain cases taking an acceptably long time to resolve – indeed the HCPC report that in 2012–2013, 27 cases took in excess of 24 months to conclude. We urge the HCPC to commit itself to a clear "start to end" target setting out the maximum time should be 12 months. Such a target represents a commitment from the HCPC to the patients and service users it aims to protect, and to its registrants, and should be clearly communicated on its website. (Paragraph 22)

We are fully committed to reducing the length of time it takes to conclude fitness to practise cases. However we do not consider it is constructive to commit to a "start to end" target of 12 months in all cases.

We take a case-by-case approach to the management of our fitness to practise cases and each case has to be managed, investigated and assessed on its own merits ensuring proportionality and fairness to all those that are involved. There are some cases which take longer to conclude simply because of the time it takes to gather sensitive information or because of the logistics of organising and taking witness statements. In those cases that reach final hearing, the logistics of arranging a hearing and ensuring the availability of all those that need to attend a hearing may lead to unavoidable delay. Where information or witnesses are not forthcoming, we may need to use our legal powers to demand information or attendance at a hearing.

There are also provisions within the legislation which require that particular notice periods are provided to those that are subject to fitness to practise action. For example, a prescribed period of time that registrants must be given at the investigation stage to provide their observations in response to an allegation. Whilst these notice periods add to the time taken to conclude cases, we consider that they are essential and provide an important procedural safeguard for those that are involved in the process.

In 2013–2014 the average total length of time from receipt of a complaint to the conclusion of a case was a mean of 7 months and a median of 5 months. 85 per cent of all cases were concluded in less than 12 months and 94 per cent of cases within 20 months.

The average length of time from receipt of a complaint to the conclusion of cases that were referred to a final hearing in this period was a mean of 18 months and a median of 16 months. 30 per cent of cases reaching final hearing were concluded within 12 months of receipt of the complaint and 68 per cent in less than 20 months.

We maintain close oversight and monitoring of our case activity to ensure that cases are concluded in as timely a manner as possible. In the past year we have developed further tools to assist us in this area. They include the following.

- A risk-based reporting system to identify cases which require immediate, high level action.

- Assigned case escalation actions and dedicated owners for those cases to ensure that they continue to progress through the process.

We have also redirected existing case progression meetings to review and manage cases that are not progressing and have commissioned an external review of our older concluded cases to identify any learning that can be applied to future cases. We have further developed a process to identify triggers in the early stages of a case that can be used to predict the impact on the lifetime of a single case. We also have strict service level standards in place with the external lawyers that prepare and present cases on our behalf at final hearing.

We will ensure that there is clearer information available in our published literature and on our website about how long it is likely to take for cases to conclude. We are undertaking a range of activity to ensure that we provide those that interact with our fitness to practise process with appropriate guidance and information. We have recently undertaken a survey of employers about their views on the material we provide, which is being used to refine the guidance we publish. We are in the initial stages of planning work as to how we can

systematically capture feedback from registrants and complainants. We already do this for witnesses who attend our final hearings. We are committed to ensuring that our communication is clear and transparent, whilst at the same time managing the expectations of those that interact with us.

Continuing fitness to practise

The HCPC told us that there is no one-size-fits-all solution to securing patient input into their continuing fitness to practise processes. In our view this should constitute an important part of any revalidation system, and we urge the HCPC to continue their efforts to include such feedback on a regular and consistent basis. (Paragraph 27)

We agree that the feedback of service users and carers has a role to play in assuring the continuing fitness to practise of the health and care professions we register.

In our evidence to the Committee we referred to research we had commissioned which looked at the utility of different tools for gaining the feedback of service users. This research identified qualitative feedback from service users in a variety of formats is most likely to have impact. We continue to advocate this more reflective and individualised approach to involving service users in giving feedback about registrants. Further evidence is required, as we know of no research that has found a link between the use of standardised measures and future performance. This research forms part of a wider programme of work which we are using to consider whether our existing system, which is based around our standards of continuing professional development and audit process, should be strengthened in some way.

Two further pieces of research are being delivered which will assist our decision making in this area. First, the Department of Health, as part of its policy research programme, is commissioning a research study which will consider the costs, outputs, outcomes and benefits of our existing approach to continuing fitness to practise. Part of this will include analysis of secondary data from in excess of 11,500 CPD audit submissions made to date by registrants. This will include looking at the evidence provided by registrants, such as feedback from service users and carers. The study will also analyse data from the audits against audit outcomes and collect additional data about the reported costs for the regulator, employers and for professionals.

The second piece of research has been commissioned by us and is looking at the perceptions and experiences of stakeholders of our CPD standards and audit process, which will provide further evidence to inform how or whether the standards or process should be strengthened. This research is due to report in June 2015.

Francis

The Francis report has thrown a spotlight on the role of health and care regulators in ensuring public protection, as healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they have about the safety and quality of care being delivered to patients. For the effective regulation of clinical and caring professions, regulators need to be visible and accessible to registrants, and also to patients and members of the public who wish to raise

concerns about patient safety. Regulatory bodies must also collaborate effectively between themselves. We recommend that the HCPC continues to monitor its own profile both with patients and service users, with professionals, and with other relevant organisations, and we will seek further evidence of the progress the HCPC and other professional regulators have made in implementing the recommendations of the Francis report at our next accountability hearings in the autumn. (Paragraph 38)

We agree with the emphasis the Committee places on the visibility and accessibility of the regulators to registrants, service users and others who wish to bring concerns about public safety to our attention. This is a challenge for all the regulators and is one that we are committed to continually seeking to address.

We agree that it is important that we continue to monitor our profile with key stakeholders. To this end we have recently commissioned new market research to look at awareness, understanding and perception of us and our regulatory role amongst key stakeholders.

In general we try to take a targeted approach to our communications activity, in order to ensure that stakeholders receive the information that will be useful to them in an accessible format and through an appropriate medium. For example, our communications activity aimed at service users has often been targeted through advocacy providers as well as referrers such as GPs, to ensure that information is available for those who need it, when it is needed.

We would also like to bring to the Committee's attention our involvement of service users and carers in our on-going review of our standards of conduct, performance and ethics. These standards set out professional and public expectations of professional behaviour. During the review we have engaged extensively with service users and carers, directly, through published research, and through membership of a working group, to ensure that our standards can take account of their experiences and reflect their expectations. This input is helping us to ensure that the revised standards when published will be accessible to a wide audience in both their content and their format. This is very important in ensuring that service users and carers have a clear understanding of what to expect of their health and care professional and who they can turn to when things go wrong. We were pleased that the Professional Standards Authority commended us for this work in their recent 2013–2014 performance review.

Turning directly to the Francis report recommendations, in response we developed an action plan to target our activity to those recommendations which were most relevant to our role. The following provides a summary of some of the key activities that we wish to bring to the Committee's attention.

- We have reviewed the effectiveness of our existing memorandum of understanding (MOU) with the Care Quality Commission in England and have recently agreed a revised MOU; a joint operating protocol setting out how the MOU will be delivered operationally; and an information sharing agreement, setting out what, how, when and with whom information will be shared. This work has been helpful in further strengthening the personal contact and trust between the two organisations, which we noted in our last evidence session is vital in making such arrangements work effectively

in practice. We plan to explore the scope for similar agreements with the other health and social care service regulators in the UK. We have agreed an MOU with the Disclosure and Barring Service (DBS) and are working towards one with NHS Protect, the organisation responsible for countering fraud and other crime in the health service.

- The Patients Association undertook a peer review of complaints handling at Mid Staffordshire. In addition to considering whether that review had any helpful learning for our fitness to practise process, we commissioned the Patients Association to peer review a sample of our complaints, namely those escalated complaints which concern individuals dissatisfied with how a case had been handled – looking at how effectively these cases had been handled and identifying opportunities for improvement.

- The Francis report made a number of recommendations for organisations involved in the delivery or regulation of specialist education and training in the medical profession to better ensure that information is gathered and shared about the safety of the practice learning environment for patients. As part of a recently commenced review of these standards, we want to consider how we might strengthen our standards of education and training (SETs) and/or supporting guidance in ways which might better set out our expectations for education providers in ensuring the safety for service users (as well as for students) of the practice learning environment.

- Finally, as part of our on-going review of standards of conduct, performance and ethics, we intend to amend our standards to better set-out our expectations of registrants around the importance of reporting and escalating concerns about the safety of service users. We also intend to set out clear expectations for registrants to be open and honest with service users and others about any mistakes they make and to take action to put matters right wherever possible. This will ensure that the standards incorporate the principles underpinning the 'duty of candour' on health professionals proposed in the Francis report. These proposals will be the subject of a public consultation early in 2015–2016, with implementation planned from January 2016.

Regulation of adult social care workers in England

The Committee is concerned by the most recent in a series of reports of abuse by social care workers. In 2011, the Government proposed a voluntary register, but no progress has been made since then and we agree with the HCPC that in any event voluntary registration would not be effective. We recommend that, as a first step to improve regulation in this sector, the Government should publish plans for the implementation of the HCPC's proposals for a negative register. The legislation that would be required to enable the establishment of such a negative register is contained in the Law Commission's draft Bill on the regulation of health and care social care professions. Beyond the establishment of a negative register, we recommend that the Government, working with the PSA and the HCPC, develop further proposals for more effective regulation to provide proper safeguards in this area. (Paragraph 54)

We welcome the Committee's endorsement of our proposals in this area, which we consider would have significant benefits for public protection.

We have met with the PSA recently to discuss our proposals.

Herbal medicine practitioners and public health specialists from 'non-medical' backgrounds

The HCPC has a record of assimilating new professional groups onto its register, and most recently the Government has suggested that herbal medicine practitioners and non-medical public health specialists should be added. Members of 'aspirant' groups such as these may experience frustration owing to delays and uncertainty, as the HCPC has reported to us that it is unable to commit resources to developing its approach to potential new groups until the Government has introduced legislation. The UK Public Health Register has raised a number of concerns relating to the proposed regulation of non-medical public health specialists. We recommend that the HCPC engages directly with the UK Public Health Register to ensure its concerns are registered. (Paragraph 72)

On 5 September 2014, the Department of Health published a consultation document on a draft Section 60 Order under the Health Act 1999 to bring public health specialists from 'non-medical' backgrounds into statutory regulation by the HCPC. The consultation document confirms Government policy that this group should be brought into statutory regulation with us, seeking the views of stakeholders on how this is best achieved in legislation. Specialists from medical and dental backgrounds would continue to be regulated by their respective regulators.

We understand that, subject to parliamentary approval, the Government plans to have legislation in place prior to the general election in 2015, with the HCPC Register expected to open to this group by the end of 2015, on a date to be agreed.

Now that draft legislation has been published, we have begun work to ensure that everything is in place to opening the Register to public health specialists by the end of 2015. This will include formally consulting with stakeholders in the sector on a number of matters prior to the introduction of regulation, including the standards of proficiency for entry to the Register.

In June 2014 a meeting was held between the HCPC, the UK Public Health Register (UKPHR) and the Department of Health to discuss this area. The UKPHR will be invited to join the HCPC's operational project meetings when they are convened. We are committed to working with the UKPHR to ensure a smooth and efficient transition from voluntary registration to statutory regulation in a timely manner. The HCPC is also represented on the Public Health Workforce Advisory Group Task Group on regulation convened by the Faculty of Public Health which provides a forum for stakeholders across this sector to discuss regulatory issues.

Statutory regulation of other new groups

In addition to this, since 2003, the HCPC has recommended to Government that statutory regulation be extended to eleven other professions. Of these, the only group[s] to receive statutory regulation to date are operating department practitioners and practitioner psychologists. Statutory regulation gives professions, in the words of the HCPC, "a huge badge of respectability, professionalism and endorsement." Decisions about whether to extend statutory regulation to different professions need to be informed both by considerations of issues of patient safety, and consideration of the

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We received written evidence from the Registration Council of Clinical Physiologists arguing strongly that Clinical Physiologists should be subject to statutory regulation, a position that the HCPC agreed with. We recommend that, in responding to this report, the HCPC lists any professional groups for which they feel there is a compelling patient safety case for statutory regulation so that we can take this further with the Department of Health as a matter of urgency. We are concerned at the length of time it can take for professional groups to gain statutory regulation. As we understand that new groups can be added to the HCPC's register by means of secondary legislation, we see no reason why there should be undue delay in extending statutory regulation to professional groups where there is a compelling patient safety case for doing so. (Paragraph 74)

We welcome the Committee's conclusions in this area. The ultimate decision about whether to extend statutory regulation to additional groups is one for Government and Parliament. However, where a decision is taken to regulate further groups, we are always very committed to working with all those involved to make this happen in as timely and efficient a manner as possible, for the benefit of the public.

As the Committee notes in its report, the HCPC has to date recommended to the Secretary of State for Health and to Scottish Ministers the statutory regulation of eleven professions, two of which have subsequently become regulated by us. These professions sought regulation by applying to the Council via its 'aspirant groups' process. They were assessed as part of that of that process as meeting criteria which included the risks and the potential for harm to the public posed by the profession and the existing systems established by the profession which demonstrate a commitment to the public and a readiness for regulation.

We continue to consider that the following groups should be considered for statutory regulation, on the grounds of patient safety.

- Clinical perfusion scientists
- Clinical physiologists
- Clinical technologists
- Dance movement therapists
- Genetic nurses and counsellors
- Maxillofacial prosthetists and technologists
- Medical illustrators
- Sonographers

- Sports therapists

In addition, we would like to draw the Committee's attention to work we undertook between 2008 and 2010 to explore the statutory regulation of psychotherapists and counsellors, in light of the 2007 White Paper 'Trust, Assurance and Safety – The regulation of health professionals in the 21st century' which said that this would be a priority group for regulation. This work involved working with stakeholders to develop proposals for how this group might be regulated, including developing standards. In 2011, the Government confirmed that it no longer intended to introduce statutory regulation for this group.

We acknowledge that in considering the extension of statutory regulation, the Government and Parliament may very legitimately wish to consider the relative merits of different groups. This is a complex political judgement involving a number of different factors including, we would suggest, consideration of the following.

- The environment in which the profession practises (e.g. managed environment, independent practice).
- The tasks or procedures typically carried out by the profession.
- The size of the profession.
- The risks of the practise of the profession, in terms of probability of harm and the severity of the consequences.
- The need for accountability and adherence to proper standards to ensure that the expectations of the public are met and that they have faith and confidence in the services of professionals.
- Whether the profession has a well-established professional body which sets clear standards.