Council, 12 February 2015

Statutory regulation of further professions

Executive summary and recommendations

Introduction

The HCPC has powers to make recommendations to the Secretary of State and to Scottish Ministers for the statutory regulation of new professions (Article 3(17) of the Health and Social Work Professions Order 2001). However, whether those professions become regulated is a matter for Government and Parliament alone.

The HCPC used to run what was known as a 'new professions' or 'aspirant groups' process by which it could consider applications from professional bodies seeking regulation for their professions and make recommendations. The process was closed to new applications in 2011 following the publication of 'Enabling excellence'. This set out the Government's policy that it would not in future consider extending statutory regulation to further groups unless there was 'compelling' evidence of patient safety risk and assured voluntary registration could be shown to be inadequate in managing that risk.

In January 2014 we were called for the first time to appear before the UK Parliament Health Committee. One of the recommendations made by the Committee as a result of our hearing was that in its response to the Committee's report the HCPC listed those professions for which it considered there was a 'compelling patient safety case' for statutory regulation.

In anticipation that we would be called before the Committee again in 2015, we wrote to the aspirant professions in July 2014. We sought evidence to support the case for their regulation which we intended to draw upon in our evidence submission to the Committee. In particular, we asked for any examples of poor practice or risk of harm over the last five years. A hearing before the Committee would have also provided an opportunity for each professional body to submit evidence direct to the Committee outlining their case.

In November 2014, we heard that the Committee did not intend for us to appear before it in this session of parliament, because of its positive assessment of our performance and owing to lack of parliamentary time. We wrote to the aspirant professions to advise. We said we would compile the information and evidence we had received from them to put together a paper to be considered by the Council at this meeting. This paper, once agreed, would then be sent to the Chair of the Health Committee, copied to each organisation and published on the HCPC website.

A draft paper is attached. A copy of our response to the Health Committee report is also appended for reference.

Decision

The Council is invited to discuss and approve the attached paper (subject to any amendments agreed at this meeting and any minor editing amendments).

As the paper necessarily only represents a summary, the Executive has sent a copy of this paper to the aspirant professions for an opportunity for them to suggest any minor amendments or to correct any matters of accuracy.

Background information

- The Law Commissions' reviews of the regulators' legislation recommended removing the HCPC's power to recommend the regulation of new professions, a proposal that the Council agreed with in its response to the public consultation.

- Background information:

  Information about the new professions process:
  http://www.hcpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/

  Health Committee (2014). 2014 accountability hearing with the Health and Care Professions Council.
  http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/339/339.pdf

  Department of Health (2011). Enabling excellence.
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf

Resource implications

- Liaison with organisations representing aspirant professions.
- Finalisation of paper, letter written to the Chair of the Heath Committee.

Financial implications

None

Appendices

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

Date of paper

29 January 2015

Statutory regulation of further professions

1. Introduction

1.1 The HCPC has previously recommended the statutory regulation of the following professions.

- Clinical perfusionists (also known as clinical perfusion scientists).
- Clinical physiologists.
- Clinical technologists.
- Dance movement psychotherapists (also known as dance movement therapists).
- Genetic counsellors.
- Maxillofacial prosthetists and technologists.
- Medical illustrators (clinical photographers).
- Sonographers.
- Sports therapists.[1]

1.2 The Health Committee has previously recommended that, in responding to its report of our most recent accountability hearing, the HCPC should list those professions for which we considered there was a 'compelling patient safety case for statutory regulation'.[2]

1.3 Since the Committee's report, we wrote to the professional organisations representing these professions to gather evidence to support their case for statutory regulation. This paper provides a short overall summary of the arguments and evidence provided. These largely concerned two overlapping areas.

- The risks associated with the activities of the professional group and associated with that group's current lack of regulation.

- The benefits of statutory regulation to the public and for the profession itself, often in contrast to the limitations of existing voluntary arrangements.

1.4 Information is then provided about each professional group.

1.5 We continue to consider that the professions listed above should be considered for statutory regulation on the basis of patient safety.

[1] Under Article 3(17) of the Health and Social Work Professions Order 2001
http://www.hcpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/
[2] Health Committee (2014). 2014 Accountability hearing with the Health and Care Professions Council. Paragraph 74.

2. Risks and benefits identified in submissions

2.1 The following provides a summary of the risks and benefits identified in submissions made to us.

Risk of harm

2.2 Professional organisations identified the risk of, and potential for, harm, as well as in some instances providing examples of actual harm when interventions are performed incorrectly. Section three provides a summary of the information provided by each professional group. The following provides an overview of the main themes. Many if not all of the risks summarised below could be said to be 'generic risks' which are applicable to all professions in health and care, including those that are already statutory regulated.

- There are a broad range of risks of harm associated with the nature of the activities / interventions involved in each profession. These interventions included (a combination of) the following.

    - Assessment, interpretation, diagnosis and treatment planning.
    - Invasive procedures.
    - Psychological interventions.
    - Physical interventions.
    - Set-up, maintenance and use of specialist machinery and equipment.

- The consequences of poorly performed interventions included poorer clinical outcomes (for example, treatments less successful because of poor assessment or planning), delayed diagnosis (for example, inaccurate interpretation of test results leading to tests needing to be repeated and delayed treatment), disabilities (for example errors leading to enduring physical or mental harm), and in some instances, death.

- The vulnerability of the patients these groups of professionals work with was also identified as a risk area.

- In some professions a majority of professionals work in independent practice outside of the assurance provided by the governance arrangements of employers. In some professions, the extent of locum working and the ease with which such work can be obtained without appropriate registration was a cause for concern.

- Professional organisations identified other factors which increased risk including high levels of autonomous working (even if within managed environments); lack of direct supervision; work in people's homes; and the highly specialised, complex and technical nature of some disciplines reducing the possibility of regular scrutiny by others.

Limitations of voluntary registration

2.3 Professional organisations, often illustrated through examples and case studies, drew attention to the limitations of the current voluntary registration arrangements in comparison to the benefits of statutory regulation.

- Organisations were unable to apply standards and fitness to practise processes to individuals who chose not to register or who removed themselves prior to, during, or as a result of, investigations.

- A lack of statutory regulation meant that alleged misconduct or lack of competence could not be dealt with properly. Employers are often reluctant to share information with voluntary organisations, delaying or in some cases halting investigations. The cost of investigations, including the potential for litigation from those unhappy with the outcomes, is challenging for voluntary registers to manage.

- A lack of statutory regulation meant that the professional title was not protected and could be and was misused by those who were not members of the voluntary register and had not completed recognised training to practice. Protection of title would help consumers to make informed choices by allowing them to differentiate between those who were qualified and those who were not.

Barriers caused by lack of statutory regulation

2.4 Professional organisations identified how a lack of statutory regulation acted as a barrier to improving service delivery and developing the profession. This, it was argued, meant that patients and service providers would not benefit fully from the safe, efficacious and value for money interventions they were able to offer.

- A lack of regulation was seen as a barrier to growing the services of some professions because of difficulties of obtaining employment in some areas without registration with a statutory professional regulator. Employers and commissioners are sometimes risk adverse and will prefer to employ other statutory regulated professionals instead or commission services involving these professions. This can in turn hold back the ability of services to meet demand.

- A lack of regulation can cause unintended inflexibility in working practices. For example, unregulated professionals are unable in current legislation to access mechanisms to administer medicines, such as patient group directions and supplementary prescribing. This can be a barrier to more efficient ways of delivering safe and effective care.

3. Information about individual professions

3.1 This section gives information about each profession previously recommended by the HCPC for statutory regulation. It gives figures for the numbers in each profession and then provides a summary of the arguments for statutory regulation made by professional organisations in response to the HCPC's request for information (see paragraph 1.3).

Number of practitioners

3.2 The table below provides a summary of the number of practitioners in each of the professions.[3]

Profession	Number of registrants

[DN: This table will provide a summary of numbers in each profession to provide an estimate of scale. This information was not provided by most groups, so will be sought for inclusion when the paper is finalised.]

Clinical perfusionists

3.3 Clinical perfusionists work as part of the clinical team during open heart surgery, using, monitoring and maintaining a number of devices, including heart-lung machines, to ensure that oxygen reaches a patient's body through the blood. They may also be involved in using their skills in other medical procedures.

3.4 The Society of Clinical Perfusion Scientists made the application for statutory regulation to the HCPC in September 2003. The College of Clinical Perfusion Scientists maintains a voluntary register.

3.5 In summary, the following arguments and evidence have been advanced by the Society and College for statutory regulation.

- Clinical perfusionists are involved in the single most invasive procedure in health care, yet patients are not afforded the protection of statutory regulation. Where mistakes are made the outcome is disproportionate, often life threatening and usually life changing with a high risk of permanent injury.

[3] 'Number of registrants' data is number of those registered with the professional organisation which made the application for regulation. In some cases there may be more than one voluntary register in existence.

- In 2005, a perfusionist accidentally administered a fatal dose of a substance to a child, illustrating the potential for harm. This led to the publication of the Gritten report which recommended a review of the regulation of clinical perfusionists. The Department of Health subsequently indicated its then intention to statutory regulate this profession.[4]

- A review of serious untoward incidents over the last five years reported to the Society which were attributable to the responsibilities of the clinical perfusionist, or for which the action or inaction of the clinical perfusionist was a significant causal factor, further indicate the potential for harm. This includes errors leading to low oxygenation; excessive blood loss; air embolus; and overdose of a controlled drug. In some cases, the patient died, suffered a stroke or suffered life changing injuries.

- The limitations of voluntary registration affect the College's ability to investigate and deal with cases of alleged misconduct by its members. In two cases, the College was unable to remove a perfusionist from its Register owing to concerns about litigation. In another case, four clinical perfusionists were found guilty of serious fraud against the NHS. In this case and in the other cases referred to here, the College, as a voluntary organisation, experienced difficultly obtaining the information necessary to investigate. In all cases, the voluntary nature of current arrangements meant that individuals could continue to work elsewhere, often as locums.

- A lack of statutory regulation creates inflexibility in working practices. As unregulated practitioners, clinical perfusionists are only able to administer prescription only medicines in line with the patient specific direction of a doctor. Without statutory regulation, clinical perfusionists are unable to access patient group directions or be considered for supplementary prescribing rights.

Clinical physiologists

3.6 Clinical physiologists are a group of healthcare workers who are involved in diagnosis and management of a wide range of conditions, many of which are sensitive or invasive. The types of clinical physiologist are: audiologists; hearing therapists; neurophysiologists; cardiac physiologists; gastro-intestinal physiologists; respiratory physiologists; and sleep physiologists.

3.7 The Registration Council for Clinical Physiologists (RCCP) maintains a voluntary register and made the application for statutory regulation to the HCPC in October 2003.

3.8 The RCCP has submitted to us information from a survey of its registrants about the incidence of complaints / concerns about the conduct or

[4] Mark Gritten (2007).Independent root cause analysis report into the adverse incident that led to the death of a paediatric cardiac surgery patient at United Bristol Healthcare NHS Trust on 27 May 2005 http://www.scps.org.uk/pdfs/GrittenReport.pdf

competence of clinical physiologists. They have also provided case studies of complaints they have dealt with. A summary is provided below.

- Survey data indicates that in 31% of cases of alleged misconduct or lack of competence the practitioner continued to work, but for a different organisation. This indicates a problem of individuals moving between institutions and locum providers in order to escape internal employer investigations. The survey data appears to indicate a higher rate of concern about locum practitioners.

- Survey data indicates underreporting to the RCCP – 77% of concerns resulted in an internal disciplinary outcome that RCCP registrants considered unsatisfactory, but reports to the RCCP were not always made.

- Survey data indicates that in 37% of cases RCCP registrants considered the issue to present a high or very high risk to patient safety, indicating that even where the number of cases reported might be low, the potential for patient harm amongst those cases may be high.

- In many of the cases dealt with by the RCCP since its creation, the registrant concerned removed themselves from its register prior to the outcome of the investigation and hearing, indicating the limitations of voluntary registration. In some of these cases, there is evidence that unregistered individuals have continued to practise, sometimes in locum roles, even where the RCCP has considered a case serious enough to merit removal from its register.

- The following provides a short summary of some of the cases.

    - A registrant was arrested for possession of child pornography and a subsequent search of their home revealed a large quantity of illegal weapons. They subsequently received a short prison sentence. The individual worked largely unsupervised with children. Although quickly removed from their employment and the RCCP register, they subsequently gained a locum post within hours of leaving the police station.

    - A registrant was the subject of four complaints from four separate hospitals within two weeks. Subsequent investigations revealed problems at a further two hospitals. These were serious concerns about their competence and conduct. Although removed from the RCCP Register, the individual gained employment in Australia where more complaints were made. The individual is now working back in the UK as a locum.

    - A registrant was the subject of a competency assessment owing to concerns about poorly carried out investigations and inadequate

reporting. As a result, they were required to undertake remedial training. They failed to do so and were removed from the RCCP Register as a result. However, they have continued to work elsewhere.

Clinical technologists

3.9 Clinical technologists are involved in the application of physics, engineering and technology to clinical practice. They perform complex procedures on patients, look after specialist medical devices and prepare treatment such as radioactive injections.[5]

3.10 The Register of Clinical Technologists (RCT; formerly the Voluntary Register of Clinical Technologists) maintains a voluntary register and made the application for regulation to the HCPC in May 2004.

3.11 The following arguments and evidence have been advanced by the RCT for statutory regulation.

- Voluntary registration is insufficient to protect the public. In many of the misconduct cases considered by the RCT over the last 12 years, the individuals concerned left the Register before proceedings had been concluded. Cases included altering a prescription; inappropriate behaviour; and convictions / cautions.

- The RCT reports that the voluntary nature of registration has meant that employers have been reluctant to share information where they have taken disciplinary action.

- The voluntary nature of registration means that there is no clear picture of the number of clinical technologists who are practising without registration.

- The complex, technical and sometimes invasive nature of the interventions performed by clinical technologists means that there is serious risk of harm if procedures are incorrectly performed. The following provides some examples of risks in different areas of practice.

    - Radiation protection / diagnostic radiology
      Risk of incorrect assessment / interpretation of results of ionising equipment leading to exceeding guidelines on safe exposure to radiation.

    - Renal technology
      Risk of air embolism, which can cause fatality, if patients do not receive proper education for the use of home dialysis equipment.

[5] There are seven different kinds of clinical technologist:
Nuclear medicine technologists, Radiotherapy physics technologists, Radiation physics technologists Medical engineering technologists, Radiation engineering technologists, Rehabilitation engineering technologists, Renal technologists

- Rehabilitation engineering
  Poor assessment and provision of assistive technologies increases risk of pressure ulcer incident and/or poorer outcomes for rehabilitation.

Dance movement psychotherapists

3.12 Dance movement psychotherapists (also known as dance movement therapists) provide therapy to clients through the medium of movement and dance. Dance movement psychotherapy is a type of 'arts therapy'. Art, music and drama therapists are already regulated by the HCPC as arts therapists.

3.13 The Association for Dance Movement Psychotherapy UK (ADMP; previously the Association for Dance Movement Therapy) maintains a voluntary register and made the application for statutory regulation to the HCPC in March 2004.

3.14 In summary, the following arguments and evidence have been advanced by the ADMP for statutory regulation.

- A lack of registration compared to the other arts therapies acts as a barrier to extending the services of dance movement therapists. Employers can sometimes be reluctant to employ therapists who do not have a statutory regulated background.

- Dance movement psychotherapists work in a variety of settings, including Community and Adolescent Mental Health Services (CAMHS), working with vulnerable patients including, for example, patients with substance misuse problems, patients who self-harm and patients who are at risk of suicide. Statutory regulation would protect these clients and demonstrate the professionalism of dance movement therapists.

- The title 'dance movement therapist' is sometimes misused by those who are not qualified and therapy confused with exercise provision. Statutory regulation would help deal with these situations.

- Client testimonials, research and service evaluations indicate the valuable role of dance movement psychotherapists, the benefits of their interventions and the value for money of their services.

Genetic counsellors

3.15 Genetic counsellors work with patients and their families to help individuals understand and deal with genetic disorders. They are responsible for interpreting family history, calculating genetic risk, organising genetic tests and interpreting complex test results.

3.16 The Association of Genetic Nurses and Counsellors represents genetic counsellors and made the application for statutory regulation to the HCPC in September 2009. The Genetic Counsellor Registration Board (GCRB) maintains the voluntary register.

3.17 The following provides a summary of the relevant information provided in the application for statutory regulation.

- Genetic counsellors work with individuals and families at vulnerable and emotional times. For example, many families attending genetic services are coping with early deaths from cancer, diagnosis of a progressive genetic condition or the recent loss of a child or pregnancy. Genetic counsellors are autonomous professionals who increasingly work independently and in the community.

- Risks of genetic counselling practice if poorly performed include those associated with lack of information or misinterpretation of test results. For example, misinterpretation of a prenatal test could lead to unnecessary termination of a pregnancy or false assurance when further screening is required.

- Other professionals such as midwives may be involved in discrete aspects of genetics, for example, discussing testing for genetic disorders with patients and referring patients onward for the specialist services of a genetic counsellor. There are concerns that without regulation and protection of the professional title there is the potential for misuse of title and the public will not easily be able to distinguish between the specialist services of the genetic counsellor compared to other professionals who have a more limited scope of practice.

- Private genetic testing laboratories are increasing in the UK, meaning that in the future more genetic counsellors will be employed in the independent sector. This will isolate them from multi-disciplinary NHS services and the governance arrangements this provides. There is concern that increased provision in the independent sector will increase the potential for practice without registration.

- Existing voluntary registration requirements have limitations and are challenging to maintain. A lack of compulsion means that professionals removed from registration owing to concerns about conduct or competence could remain in practice. There is evidence that employers

will sometimes fill vacant posts with individuals who are not registered. A voluntary register is costly in terms of professional time and relies heavily on the good will of those involved. There is concern about its long term sustainability.

Medical illustrators

3.18 Medical illustrators is a generic term for healthcare scientists who specialise in producing photographs, videos and graphical images for use in healthcare.

3.19 The Institute of Medical Illustrators (IMI) maintains a voluntary register and made the application for statutory regulation to the HCPC in September 2004. The application for regulation was for clinical photographers.

3.20 The following provides a summary of the relevant information provided in the application for statutory regulation.

- Clinical photographers undertake their work unsupervised and normally unaccompanied. In addition to photographic skills, they have to have sufficient medical knowledge to be able to discuss and interpret the clinician's requirements and manage patients during the photographic session.

- Clinical photographers have direct physical contact with patients. This includes for example, providing physical support during photography and using their hands to position patients during photography.

- Clinical photographers work with patients who are physically unwell and often psychologically vulnerable. They may not immediately understand the need to undress for images to be taken. Clinical photographers have to be able to demonstrate empathy and understanding for patient concerns.

- Clinical photographs are sensitive information given that they represent a direct likeness of the patient. There are negative consequences should clinical photographs be deliberately misused or inadvertently used beyond the purposes for which consent has been given.

Maxillofacial Prosthetists and Technologists

3.21 Maxillofacial prosthetists are responsible for restoring function and appearance to patients after cancer surgery, trauma or congenital abnormality. They assess, design, prepare, apply, fit, modify and maintain implants, splints and prostheses around the structures of the head and neck.

3.22 The Institute of Maxillofacial Prosthetists and Technologists maintains a voluntary register and made the application for regulation to the HCPC in September 2005.

3.23 In summary, the following arguments and evidence have been advanced by the Institute for statutory regulation.

- Maxillofacial prosthetists are autonomous professionals who perform invasive procedures with the potential for harm, exercising judgements which can substantially impact upon patient health or welfare. They work with vulnerable adults and children.

- There have been no formal reports or complaints to the Institute over the last five years. However, given significant changes in training, job titles of maxillofacial prosthetists, tendering of services via 'any qualified provider', increasing complex head and neck surgery options and the litigious nature of healthcare, the Institute expects that existing voluntary arrangements will become increasingly challenged.

- There have, however, been informal, anecdotal reports to the Institute which demonstrate the potential for harm if interventions are poorly performed. They include inadequate planning for surgery on young people causing post-operative complications; unexpected and unfavourable outcomes following insertion of deep buried implants; and tissue injury / damage caused by unsuitable orofacial devices (devices applied to the mouth and face).

- Patients, carers and medical colleagues often wrongly assume that maxillofacial prosthetists are regulated.

Sonographers

3.24 Sonographers specialise in the use of ultrasound and other imaging devices to produce diagnostic scans and images. They are also involved in the interpretation of images.

3.25 The majority of sonographers currently practising are regulated practitioners. Most are radiographers (who are HCPC regulated) who have undertaken postgraduate study but there will be small numbers from other regulated backgrounds. The remainder will be from unregulated backgrounds.

3.26 The Society and College of Radiographers maintains a voluntary register of sonographers and made the application for regulation to the HCPC in September 2009.

3.27 In summary, the following arguments and evidence have been advanced by the Society for statutory regulation.

- The title 'sonographer' is not protected and it is not a legal requirement to be either statutory or voluntary registered in order to practise as a sonographer. As a result, inadequately trained individuals are currently able to practise as sonographers, with associated risks stemming from operator error and missed or delayed diagnosis.

- Clinical demand for ultrasound services is rising, more quickly than the ability of the NHS to train sonographers via conventional routes, increasing the likelihood of unregulated sonographers being employed.

- The current situation contributes towards inflexibility in service delivery models. Service providers are reluctant to employ unregulated professionals because of the potential risk. Sonographers who do not hold statutory regulation because of their background are often unable to gain employment or find barriers in moving between employers.

- The perceived 'un-employability' of sonographers who are unable to access statutory regulation limits the development of educational and workforce models which might better satisfy service need. For example, it hinders the development of direct access undergraduate entry programmes into the profession because of concern that graduates cannot currently be on a statutory register.

- A lack of statutory regulation limits the ability of unregulated sonographers to perform examinations involving ionising radiation or to access mechanisms which allow statutory regulated professionals to administer medicines.

- The small number of fitness to practise cases about radiographers who practise sonography handled by the HCPC illustrate the potential for harm amongst those who are unregulated and who therefore are not subject to the same levels of accountability. Cases have included inappropriate examinations and inaccurate reporting leading to missed diagnosis.

- Regulation of sonographers would not prevent so-called 'lifestyle' scanning services from continuing to be offered (e.g. '3D/4D baby scanning') but would provide a higher level of protection for the public by preventing misuse of the title sonographer and providing standards and accountability for those who are regulated.

Sports therapists

3.28 Sports therapists give advice to sports and exercise participants on how to train and compete safely, as well as treat injuries and assist with rehabilitation. Their aim is to prevent injuries and to help those who are injured to return to full fitness.

3.29 The Society of Sports Therapists maintains a voluntary register of sports therapists and made the application for regulation to the HCPC in March 2006.

3.30 In summary, the following arguments and evidence has been advanced by the Society for statutory regulation.

- A lack of regulation means that inadequately trained individuals are currently able to practise as sports therapists, with risks of physical harm if sports therapy techniques are poorly performed.

- The title ‘sports therapist’ is not protected. There have been examples of unregistered individuals using the title ‘sports therapist’ without the qualifications to do so. In one instance a physiotherapist struck off by the HCPC has continued in practise using that title. In these cases the ease with which unregistered individuals can use this title without qualification or registration is concerning.

- There have been cases of unregistered, unqualified individuals purporting to be sports therapists who have been convicted of serious criminal offences. For example, an unregistered sports therapist was convicted of a number of indecent assaults against female patients and received a custodial sentence. The investigation took some time during which the individual was able to continue practising. If the profession was statutory regulated, it would have been possible for the regulator to consider taking interim action to prevent continuing harm to patients.

- In another case, it was determined that there was inadequate evidence to bring criminal charges, but the evidence nonetheless indicated that an unregistered individual had formed an inappropriate relationship with a patient and their family and had forged training documents. If statutory regulation had been in place, these matters could be considered as misconduct by the regulator and appropriate action taken.

- The majority of Society members undertake self-employed work, often autonomously, outside therefore of the governance arrangements put in place by employers, increasing the potential risk of their practice.

- The statutory regulation of sports therapists has wide support in the industry, including amongst education and training providers, service providers and users of services such as the premier league and the Football Association (FA).

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

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)

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.