hcpc health & care professions council

Research report

The making of a multi-professional regulator: the Health and Care Professions Council 2001–15

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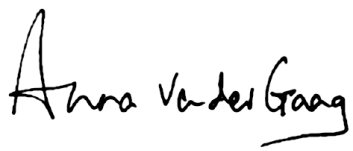
Foreword

This report is an account of the making of a multi-professional regulator over its first fifteen years. It reflects my personal views rather than the views of the Council or Executive, but I hope that both past and present employees, and Council members, will see themselves and their achievements reflected in the story. For those outside the organisation, with an interest in professional regulation, there may be useful insights into similar challenges in other contexts.

In 2001, the Health and Care Professions Council took over the regulation of twelve professions from its predecessor body. Since then, the organisation has increased the Register by 80 per cent and its employees by more than 400 per cent. Our partners, who work for us on the day-to-day decisions of regulation, have grown from 250 to over 800. The organisation has successfully managed significant growth, something which, in cultural and operational terms, is a high-risk exercise. It has added four professions to its Register, created an evidence-based regulatory culture, and re-structured its governance three times. It has been proactive in its approach to regulation and regulatory policy, both nationally and internationally.

We have achieved something that no other health and care regulator has – a wholly integrated system of professional regulation for 16 diverse professions. This has evolved from a strong commitment to open, collaborative ways of working, whilst all the time maintaining a ferocious focus on the central, unifying objective of protecting the public.



Anna van der Gaag CBE
Chair
Health and Care Professions Council, 2006–15

Acknowledgements

As a member of the Shadow Council from its inception in 2001, later as Council and Committee member, and Chair of the Health and Care Professions Council (HCPC), I have worked alongside dedicated and distinguished colleagues over many years. I consider that 'the team' at the HCPC extends to all the employees, partners and Council members who have been part of this extraordinary organisation, and I would like to thank them all. It has been a huge pleasure as well as a privilege to work alongside them.

There are a number of people who I would particularly like to acknowledge:

Professor Norma Brook, Chair of the HCPC from 2001–06. She was tenacious, grounded and deeply committed to the work. She died in January 2009 after a long illness;

Marc Seale, Chief Executive of the HCPC. An exceptional leader, whose steely determination and constant vigilance have been vital to the success of the HCPC;

The Executive Management Team, Michael Guthrie, Kelly Holder, Greg Ross Sampson, Abigail Gorringe, Jacqueline Ladds, Louise Lake, Teresa Haskins, Guy Gaskins, Andy Gillies – all outstanding directors for whom I have great admiration;

There are of course also past Council members, many of whom were with me at the start. I would like to acknowledge, in particular, Di Waller, Eileen Thornton, Morag McKellar, Keith Ross, as well as Annie Turner, Jeff Lucas, Mary Clark Glass, Sheila Drayton, John Harper and John Donaghy, who joined the Council at critical times in its history; and the current Council, who encouraged me to write this report; and

Jonathan Bracken, Special Counsel, who has played such an important role in the development of the HCPC over many years.

Use of terms

Although the organisation was called the Health Professions Council until 31 July 2012, I have generally referred to it by the current name, the Health and Care Professions Council for consistency, except in the first chapter.

The views expressed in this report are those of the author and not the HCPC.

1 Establishing the Council

The health of an organisation depends upon good processes and constructive relationships. To maintain both, all of the time, requires continuous investment, innovation and imagination.

The Health and Care Professions Council (HCPC) is one of twelve professional regulators of health and care professions in the UK. Together, they regulate more than 30 health and care professions across the four countries of the UK. Income is derived from the professionals themselves, who are required by law to pay an annual registration fee in order to practise. Professional regulators are responsible for setting standards, approving education programmes and investigating complaints about individual practitioners. They hold public registers of the names of individuals who meet professional standards. Through these processes, they provide the public with the benchmarks of good professional practise and a level of protection against poor practise.

The Health Professions Council (HPC), as it was known when it was established in 2001, was the UK's first multi-professional regulator of twelve professions. It replaced an existing regulatory body called the Council for Professions Supplementary to Medicine (CPSM), which regulated twelve professions, each with its own separate board. The CPSM was established in 1960, and by 1965 it had 26,000 professionals on its Register. Various reports had recommended reforms to the CPSM and this eventually led to the drafting of new legislation that would underpin the work of the new regulatory body. In many respects, the new legislation could be described as progressive, radical even, challenging many existing assumptions about the health professions and how they could be regulated.

The legislation governing the CPSM was significantly different to the new HPC legislation. One significant difference was accessibility. Members of the public could not complain to the CPSM without getting a sworn affidavit from a solicitor. The CPSM standards focused on conduct, not competence. The powers of the Council meant that all investigations were restricted to investigating 'infamous conduct', and could not take into account ordinary misconduct, health or competence issues. The two outcomes from a disciplinary hearing where a finding was made were: striking off or postponed judgement. As a result, only cases likely to lead to removal were progressed to a hearing, meaning that no action was taken on matters which, though serious, did not appear to warrant such an action. In contrast, HPC legislation set standards of competence or proficiency as well as conduct. Its legislation allowed investigations about competence as well as conduct and it had a wider range of sanctions. In addition it was 'convention compliant' legislation. This meant that all aspects of HPC's legislation complied with the Human Rights Act, underpinned by principles of accessibility and transparency.

The HPC was established as a shadow organisation until it was ready to take over the regulatory functions from the CPSM. By April 2002, the Council was fully operational, with 132,000 names on the HPC Register. By 2015, the number of names on the Register had risen to 330,000 (see Appendix for details of growth in numbers and a list of professions).

Many had reservations about the change to the HPC, and there were a number of reasons for this. First, the CPSM had twelve separate boards, one for each profession, who were legally autonomous in dealing with registration and education decisions independently of one another. The HPC, on the other hand, had one Council made up of members drawn from all twelve professions and an equal number of lay members. The regulatory functions of the HPC were to be fully integrated and no longer carried out by separate boards for separate professions. This was seen as a retrograde

step, representing a move away from self-regulation. Second, many of the professional bodies had their own systems in place for disciplining their members. The CPSM's disciplinary committees were frequently considering matters that had already led to removal from the professional body membership. Similarly, the work of the joint education validation committees were driven by the professional bodies criteria. All of these functions were now to be delivered by the new body, where the integrated Council, the HPC partners and the employees of the HCPC worked together. This was a huge change for the professional bodies and their relationship with the regulator.

The first task of the Shadow Council was to establish standards. The legislation specified that the Council would establish four sets of standards. These were the:

– Standards of education and training;

– Standards of proficiency, which described the skills and knowledge of the profession;

– Standards of conduct, performance and ethics; and

– Standards of continuing professional development.

At the same time, the Council had to establish a new committee structure to oversee the four regulatory functions of education and training, registration, disciplinary (fitness to practise) and continuing professional development.

A second key task was to appoint a Registrar. The Shadow Council approved the appointment of Marc Seale as Chief Executive and Registrar in November 2001. CPSM's Registrar was still in post, which meant that the new Chief Executive began setting up processes whilst the old structure was still functioning in the same building. Marc quickly recruited his Executive team, which included Greg Ross Sampson. A small number of the CPSM Executive moved over to the new team. The transition to a completely new Executive team evolved over the next 18 months, and they were critical to the establishment of HPC's processes.

The task before the Executive was considerable. There was new legislation, a new Council, no standards or processes, and a small staff team. Bircham Dyson Bell's legal counsel, Jonathan Bracken, who had acted for the CPSM over many years continued to work closely with the Council and Executive as it began to formulate new ways of working.

The Council and the Chief Executive needed to establish the new processes as quickly and efficiently as possible. Meetings were often taken up with lengthy debates about the wording of the new legislation, and how it should be implemented. As so much of what the HPC was doing was without precedent, there were quite different and sometimes strongly held opposing views around the table. The tension was often between those who had invested in the CPSM ways of working, and those who were focused on the goal of a multi-professional model of regulation. Self-regulation was still seen by some as the most robust method of approaching all the regulatory functions, and the discord, in those early days, was frequently between lay and professional voices. There were also sub-groups of professional members, who found themselves agreeing and disagreeing on issues, arguing with their lay counterparts.

1.1 The Council and committee structure in 2001

1.1.1 The Council

The Council had 24 members; 12 registrant members nominated by their profession, and 12 lay members and a Chair appointed by the Privy Council. In addition, each profession had an alternate member, also nominated by their professional body. Alternates were appointed to attend meetings in place of the professional member, and to populate the committees of the Council as required.

The lay members of Council were drawn from a wide range of backgrounds and interests. At least one appointed lay person had to come from each country of the UK, living and working there.

Once the Council was established, registrant members of Council had to stand for election by their profession. This led to further changes in the composition of the registrant members of Council, as some members did not receive sufficient votes from their profession to remain on the Council.

1.1.2 The committees

In addition to the Council, there were several statutory committees; the Education and Training Committee, and the Fitness to Practise committees. These were divided into Investigating, Conduct and Competence and Health committees, initially populated by members of Council and their alternates. In addition there were four non-statutory committees; Registrations, Approvals, Communications, Finance and Resources, and Audit (see Appendix for further details).

Like the Council, the committees' priorities in the early years were to work with the Executive on establishing processes, operationalising the legislation. The Executive were frequently starting with a blank sheet of paper, and bringing their proposals to the committees for discussion and approval. The details of how the registrations process would work, what the visitors to education programmes would do and how allegations would be dealt with were all laid out in the legislation, but they needed to be translated into detailed procedures. This was a time of great innovation and change, and there were many lively debates about how best to make the HPC deliver its objectives.

1.1.3 Establishing the Partner role

Without doubt, one of the components of the HCPC's success lay in the creation of the Partner role. HCPC 'partners' were, and still are individuals recruited through open competition to make the day-to-day decisions of regulation. They are lay and professional people, drawn from all the health and care professions, and from education, research and management roles. They bring a huge range of expertise within and outside the professions, and without them, the HCPC could not do its work. They assess applications to the Register, visit education programmes, sit on fitness to practise panels and assess CPD profiles. Once established, the partners function included annual performance reviews and appraisals, allowing the organisation to monitor and maintain consistency across the roles. Crucially, all partners from all professions are treated in the same way. As each new profession was added to the Register, new partners were recruited to ensure that those with knowledge of the profession were involved in regulatory decision making. In 2003, there were 250 partners. By 2015, this number had risen to 824.

2 Establishing standards and regulatory processes

2.1 Establishing standards

From very early on, it was clear to the Council and the Executive that the standards were central to the HCPC's success. If the standards were fit for purpose and accepted by the public, the professions, educators, employers and professional bodies, then the HCPC would be well positioned to deliver robust multi-professional regulation. The challenge was that no organisation or group of people had ever attempted to produce such a set of standards before.

Under the Council for Professions Supplementary to Medicine (CPSM), each profession had 'Statements of Conduct' which in the early days were fairly general statements allowing professionals to exercise their own judgements about conduct. In later years, more specific statements on areas such as advertising and confidentiality were included. In relation to education standards, there were differences between the boards but in the large they based their decisions about education approval on the curricula developed by the professional bodies.

The HCPC had a number of reference points to work from. Many of the professions had subject benchmarks, developed under higher education's Quality Assurance Agency (QAA). There were also a plethora of professional body standards. Universities had their quality assurance frameworks and employers had their standards, all of which were used as reference points in the development of HCPC standards.

2.1.1 Standards of education and training

The Education and Training Committee (ETC) played a critical role in the development of standards and processes. Introducing a new quality assurance process into an already complex landscape was a huge challenge. This was at a time when the Committee was establishing itself and building new relationships with the sector. The goal of achieving a robust system that was fit for purpose across all education programmes in all education settings, seemed at times unobtainable. The Committee had educationalists from all the professions working alongside five lay members, many of whom were very experienced senior academics themselves, able to take a strategic view when professional turf wars began to take hold. Strong views and disagreements were commonplace at these meetings. It took many months, and much external consultation and negotiation to arrive at draft standards and to establish the corresponding processes. At the conclusion of these debates, the ETC agreed the organising principles for the new standards. They needed to be flexible, non-prescriptive, focused on outputs not inputs, facilitate innovation and allow the providers to develop programmes relevant to service and student needs. This represented a significant change in emphasis for many stakeholders.

One of the major challenges was to negotiate a new relationship with the professional bodies, who, under the CPSM, had an established role in the education approvals process. Indeed, the approvals process under the CPSM had in large part been based upon the professional body curricula. Some of the professional bodies were unhappy about the shift of responsibility to the HCPC, and felt that the organisation simply did not have the education or professional expertise required to do the job. This was one of many contentious consequences of separating the role of professional body and regulator. A new role for the professional bodies, that of 'critical friend' emerged. This demarcation of the role of the two bodies was repeated whenever a new profession became regulated by the HCPC, where the move was from a voluntary register to a statutory register. Over time, this became the accepted norm, but not without considerable opposition at the start. In time,

professional bodies established their terms of reference with the educational establishments, and some offered joint visits with the HCPC. The ETC had made it clear that, although the regulator set the standards of education and training, the curriculum remained in the hands of the professional body, as the keeper of the body of knowledge of the profession. This delineation became clearer over time, and it took longer for some professional bodies to accept it than others. Once the educational institutions showed a willingness to receive this expertise alongside the HPC process, and the professional bodies made their own financial arrangements around providing this service, the new approvals process began to settle down.

A second major challenge came around the time that the HCPC had completed the transition work from the CPSM, which was not fully completed in the education sector until 2004. When the new standards of education and training were introduced, the HCPC made a policy decision to introduce open-ended approvals along with them. This meant that all programmes were still required to submit annual monitoring information, but were not subject to the five-yearly cycle of visits as they had been in the past. Where a major change was planned, the programme was required to inform the HCPC via a separate, so called, major change process. This submission could trigger another visit, which would assess whether or not the changes meant that the programme was no longer meeting the standards.

Many of the visitors to the programmes at this time were also members of the Council and the ETC. In the early years, this link provided useful feedback on the practical aspects of the approvals process, which, as the processes became more established and the Executive and Partner team expanded, became less critical. The Council took a decision in 2006 to stop Council members chairing fitness to practise panels, even before the legislation changed to prevent this happening. This was based on the principle of separation between the role of the Council in setting policy and strategy and oversight and 'transactional' decision making in the core processes. This decision applied for education processes as well. In 2008, the Council decided to break the link completely, so that no Council or committee member was involved in this side of the work.

2.1.2 Standards of proficiency

The HPC's approach to the drafting of the standards of proficiency (SOPs) was to engage with the professional bodies, educators, and employers as fully as possible. Norma Brook led much of the early work, along with other members of Council such as Di Waller, Morag McKellar, Robert Jones, and Mary Crawford, who had been involved in standards development for their own professions and in other contexts. Di Waller and Morag McKellar also brought their understanding of the CPSM and were enormously important in these early stages.

All the professional bodies were invited to nominate their representatives, who worked alongside lay and registrant Council members and the Executive to produce the first draft standards describing the knowledge and skills required of each profession. The HCPC was proposing a generic framework of standards for all the professions, and a subset of profession-specific standards, which were linked to the generic standards.

There were a number of occasions when all the professional body representatives and the Council members gathered to scrutinize the draft standards. Some of these meetings were particularly fraught, as professional representatives objected to the common framework, or disagreed with the wording of a particular generic standard. It took many months before the Council approved the draft standards for consultation. The feedback from

this stage of development also produced many objections from the professions, many of whom did not agree with the new framework. The standards were published in 2003.

The Council also had powers to establish standards for post-registration qualifications. It did so for supplementary prescribing. Chiropodists / podiatrists, physiotherapists and radiographers who had this qualification had their entries on the HPC Register 'annotated' to show the public they had undergone additional education and training in these areas. In 2013, the DH allowed chiropodists / podiatrists and physiotherapists to train to become independent prescribers and those who completed the training were also annotated in the HCPC Register. Prescribing standards were developed to support the annotation and there are plans to extend supplementary and independent prescribing rights to other professions in the future. In 2011 the Council agreed criteria for when it might consider annotating the Register, making it clear that, as a regulator, it would only annotate additional skills that were critical to patient safety. The Council agreed to move towards annotating the Register for podiatrists practising podiatric surgery and this work is due to complete in 2016. The standards for annotation included standards for education providers as well as standards for individual practitioners.

2.1.3 Standards of conduct, performance and ethics

Alongside the work on the SOPs, the CPSM's standards on conduct were reviewed and revised to bring them into line with contemporary practice. They were consulted on in 2002, and published in 2003.

As with the SOPs, these standards were reviewed and revised in 2008, and again in 2015. The Conduct and Competence Committee led the first changes. As with all standards, the Executive held a consultation, and further minor revisions were introduced.

In 2014, a more comprehensive programme of review took place, this time involving users of services across mental health, and with acute and long term conditions. User and carer groups were invited to design their own methods for seeking feedback on the standards, with no direct steer from the HCPC. In addition, the HCPC commissioned independent research prior to the establishment of a professional liason group (PLG). This group consisted of a broader mix of contributors, who reviewed the research findings and recommendations from the focus groups, and produced the first draft of the revised standards. These were noticeably different from previous standards in terms of language and format. They were more accessible, more succinct and more contemporary. For example, they included new reference to the use of social media, and contained a new standard on reporting concerns. The standard on infection control was removed, as this was no longer deemed applicable to all registrants.

2.1.4 Standards of continuing professional development

The Council decided early on that it would not establish standards for continuing professional development (CPD) until all other standards and processes were fully operationalised. Once the SOPs, SCPEs and SETs were established, the Council began its work to devise new standards for CPD. A PLG was established in September 2005, made up of ten members and alternate members of Council, and Chaired by Eileen Thornton. From the outset, this group pro-actively sought to listen to the views of a wide range of stakeholders. This was to become an important model for stakeholder engagement.

The PLG was charged with the task of defining what CPD would mean in a regulatory context, articulating the standards and then devising the process whereby registrants would be audited against these standards.

The definition of CPD was derived from an important document authored by the Allied Health Professions Project on CPD (DH, 2003). This group had undertaken a considerable amount of work on CPD amongst the allied health professions over several years. The definition proposed by the PLG in February 2006 was as follows.

"CPD is a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice."

The five CPD standards were drafted with a clear focus on the outcomes of learning, rather than the amount of time spent on activities. There had been a great deal of discussion at the PLG and with stakeholders about whether the HPC should set minimum numbers of hours, or adopt a points-based system similar to those used by professional bodies and medical colleges. The PLG decided to advocate an approach that enabled flexibility and encouraged reflection on practice, and an outcomes-based approach, rather than an inputs-based approach. There were a number of reasons for this. First, the evidence suggested that an outcomes-focused approach was more likely to have an impact on practice. Studies showed that collecting points on a CPD scheme did not necessarily mean a practitioner would find the activity useful or helpful to practice. Utilising different kinds of learning rather than just formal training, incorporating informal, self-directed learning and individual and group based learning, were also seen as beneficial. Second, the PLG were mindful of the very different circumstances of practice across the professions, in terms of location, hours, and clinical, managerial, or educational contexts. Access to CPD budgets varied widely. The PLG therefore wanted to devise a set of standards that could be applied to all the professions across all contexts. Third, the PLG were of the view that learning should always aim to provide benefit to patients and service users, and improve the quality of service provided. This meant investing in activities that were focused on the service user or patient and the service, which could, where relevant, be taken to mean students, other professionals or other users of the service. The example often cited at the time was that, for an occupational therapist, a Masters degree in astrophysics was probably not going to provide benefit to patients, and therefore would not be considered as an activity which would help meet the HPC's CPD standards.

The first drafts of the standards, put forward in February 2006, were as follows.

1. Maintain a continuous, up-to-date and accurate record of your CPD activities
2. Demonstrate that your CPD activities are a mixture of learning activities relevant to your current and future practice
3. Seek to ensure that your CPD has contributed to the quality of your practice and service delivery
4. Seek to ensure that your CPD benefits your service user
5. Present a written profile containing evidence of your CPD upon request

The PLG emphasised that the approach aimed first and foremost, to reinforce professional autonomy. It was designed to encourage individuals to work together with their line managers, or alone if self-employed, to reflect on their learning needs and plan activities that could help to meet those needs. It formally recognised CPD as a part of registration, whilst acknowledging that the majority of professionals were already committed to ongoing learning.

The PLG also devised the requirements for the HCPC audit of CPD activities, and detailed guidance on which activities could be

undertaken as part of CPD. The audit process was linked to the two year registration renewal cycle for each profession.

Once the Council had agreed the draft standards, they were sent out for consultation. Around 1,500 responses were received. Many individual respondents and some professional bodies did not agree with the new outcomes-based approach, and in the early days there was some quite hostile opposition to the standards. However, there were others who welcomed the approach, and were supportive of the HPC in its search for a reflective, patient-centred methodology. During this time, there were a great many meetings and discussions with stakeholders throughout the UK. All the professional bodes were invited to draft exemplars of audit profiles for their professions, which were published on the HPC and professional body websites in order to give registrants profession-specific material to inform the preparations for compliance with the new standards.

The final version of the standards and guidance on the audit process were published in July 2006. The HPC took a great deal of care to ensure that registrants who were unable to submit profiles due to maternity leave, bereavement, or other personal circumstances, were permitted to defer their audits until the next registration renewal period.

During this period, both during the consultation and after the standards were published, the HPC orchestrated an extensive programme of events on the new CPD approach. 256 events with 39,000 registrants were held throughout the UK. Many members of the Council were involved in these events, which aimed to inform registrants about the approach and allow questions and comments to be raised. One of the benefits was that the events brought individuals from different professions together, and there was as much learning from other participants as there was from the HPC. People shared their experiences of recording and undertaking CPD activities and discussed, sometimes with great passion, their views on the approach.

During this period, the Executive were also preparing for the audit process, recruiting and training CPD assessors to review and score the profiles. The first CPD audits were in 2008, with the vast majority assessed at the HPC during assessment days. Increasingly CPD profiles were received by email, rather than post, so assessments started to be carried out remotely, with pairs of assessors working together. This has been more efficient in terms of time and resources.

Chiropodists and podiatrists, and operating department practitioners, were the first professions to be audited. Advice from the statistical unit at the University of Reading led the Council to decide on an initial random sample of 5 per cent, which was lowered to 2.5 per cent after these first two professions had been audited.

As registrants submitted their profiles for auditing, the HPC produced reports on the outcomes, and continues to produce these reports on a bi-annual basis (view on our website). To date, around 12,000 profiles have been assessed.

2.2 Establishing regulatory processes

Alongside the creation of the standards, the Council was required to establish new processes for registration, education and fitness to practise. In these early years, there were significant changes on the employee side, which escalated once the HPC took on full responsibility from the CPSM executive. The achievements of those early years are a testament to the commitment and leadership of the HPC's directors, and to their teams.

2.2.1 Registration

The CPSM's original registers were leather bound books, comprised of names of individuals from the professions deemed eligible to practise. By the late 1980s, all the registers were gradually computerised. Once regulation was taken over by the HPC, the Executive escalated its work to update the registration processes. There had been a huge amount of preparation during the shadow phase, but it was not until the HPC took over responsibility that modernisation really began to take shape. In 2010 the Executive introduced online re-registration processes, a significant development in the IT infrastructure which required careful preparation. By 2014, the majority of registration processes were paperless. The scale and pace of change in this department was considerable. Its strong and consistent leadership, and team focus on customer service have contributed hugely to its success.

2.2.2 Education

Under the CPSM, the administration of the approval of programmes for each profession was almost entirely in the hands of the Education committees of the boards. The administrative staff at the CPSM supported the committee's work. When the HPC took over, the ETC's members and its Chair oversaw much of the early operational work to establish the quality assurance systems. Over time the education approvals process became a co-production involving the Education team, Education and Training Committee and the partners. The flexible, innovative, output-focused approach devloped by the team has allowed diversity in programme delivery to flourish within a robust system of regulation.

2.2.3 Fitness to practise

Each Board of the CPSM had an Investigating Committee and a Disciplinary Committee. When the HPC was established, the legislation created one integrated approach to all the professions. Through this function, the Council was charged with establishing 'effective arrangements to protect the public from persons whose fitness to practise was impaired' (HPO, Part V, 21 (b)).

Three practise committees were established – Investigating, Conduct and Competence, and Health, and the legislation determined which cases were heard by which committee. In addition, the Council was given powers to appoint screeners, who could refer cases to the committees. It also had powers to refer cases for mediation.

The range of sanctions permitted by the committees was quite different from what had gone before. CPSM rules allowed the committees to remove an individual from the Register if convicted of a criminal offence, or if 'guilty of infamous conduct in a professional respect'. Under the new regime, individuals could be struck off the Register if a finding of impairment was proved, but in addition to this, suspensions, conditions of practice and cautions could be issued. It was for the HPC to prove an individual had not adhered to the standards and as a consequence, his or her fitness to practise was 'impaired.'

Amongst the important elements of the HCPC's legal framework was that it operated under the civil rules of evidence and the civil standard of proof. Panels assessed evidence on balance of probability, rather than the criminal standard. This was an important difference, which, over time, became the standard across all professional regulators.

The HCPC's legislation also required that hearings were held in the country of residence of the registrant, a new practice for regulators when it was introduced. There were a number of other significant improvements. The HCPC, unlike its predecessor, had powers to require information from employers, making the process of investigation much more timely. Another important difference lay in its powers

to issue interim orders, where it had cause to believe that a registrant was a danger to the public or to themselves.

These additional powers and new ways of investigating complaints meant that the HCPC had the legal framework to deliver a more contemporary model of regulation, applicable across all professions. The process exists to assess whether or not the practitioner's ability to practise safely and effectively is impaired. It does not seek to 'punish' registrants for past actions, and is not a general complaints process for complaints about hospital waiting times or car parking facilities. The processes therefore centre on establishing the facts, establishing whether or not the facts amount to a statutory ground, and in consequence whether or not the registrant's fitness to practise is 'impaired'.

The HCPC's fitness to practise work involved lay people and professionals from the outset, and has evolved into a system which is less adversarial than its predecessor, providing justice which is more accessible, using language that is, as far as possible, free of legal jargon. One of the challenges over the years has been finding ways of addressing the common misunderstandings about the fitness to practise process and its purpose. The HCPC has invested hugely in research and communications and in making the process clear and transparent (Moore et. al. 2013). Moreover, the Fitness to Practise Department has made every aspect of the process available online to all. It is described in detailed guidance called Practise Notes. Accounts of the process are available in multiple formats, languages and mediums via the website. The department has been at the forefront of innovation and accessibility, and continues to be referenced as an example of good practice within and beyond the sector.

Establishing standards and processes is perhaps the best example of how the HCPC worked collaboratively with its stakeholders, involving them in decisions and ensuring that consultations on changes always took place. Creating these standards and processes was painstaking, detailed work. Like many other achievements, it could not have happened without intelligent leadership and a strong collective determination to succeed. Many outside the organisation were expressing doubt that such a system of multi-professional regulation was even possible.

3. Culture and Values

So what makes and keeps a good culture in an organisation? Someone said you can smell it, you can't measure it, but you know it's there. Culture is like the air we breathe, it's the oxygen that allows us to thrive. Culture is about habit.

At the start of the HPC, when the Council was in shadow form, there was no formal discussion at Council about culture or values. The focus was on drafting standards, establishing processes and building constructive relationships internally and externally. Explicit reflection on concepts like values or culture was not part of the early years narrative. However, the literature on establishing 'successful' organisations and communities, suggests that there are three important ingredients, all of which were present at HPC from the start. First, there must be individuals who recognise each other's different skills and strengths. Second, there must be a range of skills and expertise to draw upon, and third, there must be a shared sense of purpose and shared goals (McKnight, 1995). The Shadow Council and the Executive did, in broad terms, bring the right mix of expertise to the task and, most of the time, held true to their shared sense of purpose.

Once in post, the Chief Executive established the organisational principles upon which the employees carried out their day-to-day work, but it was not until much later that the Council itself began to discuss culture and values in any explicit way. There was, for example, a strong day-to-day commitment on the part of the Council and the Executive to transparency, particularly when it came to decision-making (see Governance section). Meetings were held in public, and papers were only discussed in private under particular legal or contractual constraints.

3.1 The HPC's values in 2006

- Protect the public
- Communicate and respond
- Work collaboratively
- Be transparent
- Provide value for money
- Deliver a high quality service

3.1.1 Protect the public

This was the HPC's core organising principle, its primary objective. In 2008 the Executive and Council decided this should be separated from the other values, and communicated as the core objective rather than a value.

3.1.2 Communicate and respond

This was later revised as 'responsiveness' incorporating the expectation that, to be responsive was to communicate in a timely way. This value was underpinned by service standards across the whole organisation.

3.1.3 Work collaboratively

Fundamental to the day-to-day work, both internally and externally, was a commitment to work with others, to recognise skills and expertise, and not to work in isolation.

3.1.4 Be transparent

This value pervaded meeting structures, (the majority of meetings of Council held in public), major policy decisions, information on the website (many comment on the extent of information provided on the website). As a public body, meetings with external stakeholders were, in the main, held 'on the record'.

3.1.5 Provide value for money

This manifested itself in many ways – the maxim 'it's always easy to spend other people's money' widely used. Decisions about spend were always mindful that, as a public body, we were charged with spending money wisely.

3.1.6 Deliver a high quality service

This tied in closely with the culture of continuous improvement, and a commitment to ensure that all 'services' provided by the organisation were of a high standard. Achieving and maintaining ISO certification was an important indicator of this commitment.

All of these were aligned with what became known as the 'can do' culture of the HPC, the sense that people were working to a common goal, and prepared to give the time to find solutions. For the Executive team, this often meant long hours and lengthy discussions. For the organisation, leadership on values was crucial. For culture to become 'a habit' there had to be consistency and continuity in 'living the values' day to day.

In 2008, the National Audit Office (NAO) was invited to undertake an organisational health check of the HPC. Employees, members of the Executive team and Council members were interviewed, observations were made and a report was produced. The report praised the strong culture of continuous improvement at all levels of the organisation and the quality of leadership. By this time, the Executive had established its internal audits through BSI and ISO 90001, ensuring that all processes were checked against internal standards. This kept the organisation focused on efficiency and value for money principles. The NAO report also described the culture of the HPC as having good 'buy-in' to its organisational values and mission, highly motivated staff who embraced change and a non-hierarchical structure and attitude.

In 2007, the Council had begun a more explicit process of reviewing the HPC's values and organising principles and becoming more engaged in discussion about organisational culture. This had a positive effect on the members but also on their understanding of the Executive and the particular style of leadership that characterised the Executive team. They were passionate, committed, constantly looking for ways to improve, supportive and fiercely defensive of the organisation and its way of working. Once these conversations had taken place, the Council began to articulate the relationship between the values of the organisation, and the need for values to find expression in all aspects of the work. The imperative to be a 'learning' organisation at all levels, to conform to principles of fairness and accountability, and to be proactive as well as reactive became important themes to which the Council returned on many occasions over the coming years. Its own desire to 'live the values' and to be individual and collective role models remained strong throughout all the restructures. In the 2009 strategic intent document, the Council described the relationship between values, the social context in which the HPC operates, and its business culture.

This was an important milestone in the Council's understanding of itself and its way of working, particularly for those members of Council who came from an exclusively public service and predominantly health service background and who were suspicious of the business culture. The reality was that the operational side of the HPC was a business, and many of the principles of good practise in business were being applied to its work. Once this was clearly articulated and understood, there was a greater sense of cohesion between the Council and the Executive.

3.2 Management style and culture

One of the distinctive features of the Chief Executive's style was to meet and greet all new employees, and brief them on the ethos of the organisation. One key consistent message was: if you have a good idea, share it. If you see a better way of doing something, tell your line manager. If you want to go on a training course to develop your skills, we will support you wherever we can.

From the outset, the management structure was 'flat' by comparison with other organisations. The offices were open plan. No-one had their own office. The senior executives all had desks alongside their teams, including the Chief Executive. These outward signs of equality have been an important influence on the culture of the HPC, often commented upon by new employees and by visitors.

The other important ingredient noted by those new to the organisation was that the employees were welcoming and helpful. The notion that culture is 'like the air we breathe' suggests that it is not something that comes and goes but is part of the way of being and the way of working.

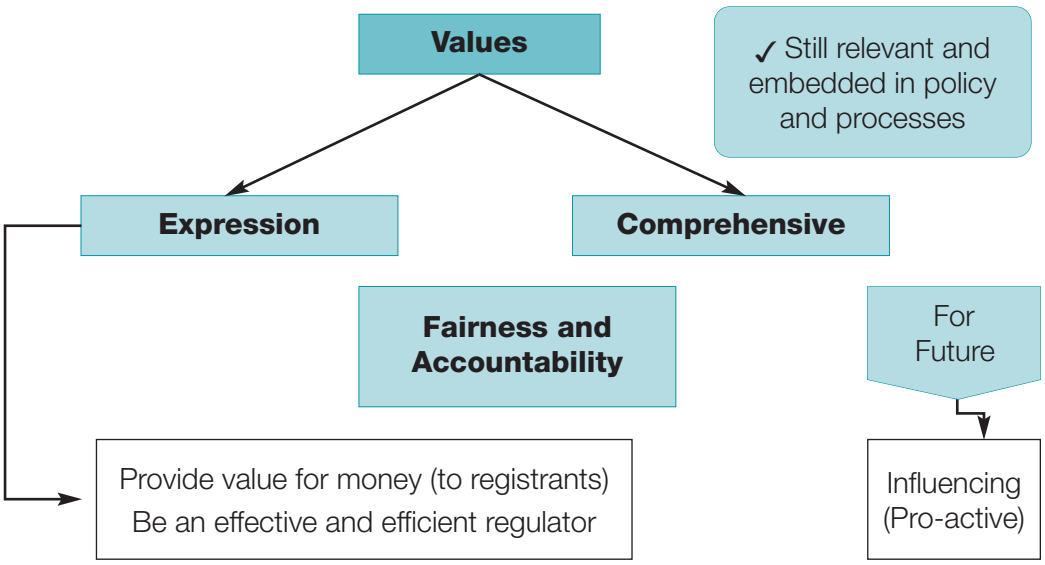
During the really hectic months leading up to the [social work] transfer, I was in the Registrations Department quite a lot. I was there during the evening shift, and I spoke to some of the temporary staff that were in. Of course, they didn't know who I was, I just went up and chatted to them. One woman, I remember, worked as a teaching assistant in a school for children with autism during the day. She said: this is a great place to come to after my working day. Everyone is so friendly, helpful, and professional. It's a good culture. I really like working here. There is a real sense of purpose here.

Friendly, helpful, professional, and a real sense of purpose. Even on the bad days, when you don't feel like being friendly or helpful, or professional. Good words to describe us, don't you think? I've said before how important it is that people who join us feel welcome, but also have a sense that we know why we are here and what we are doing, and that we look out for each other, treat each other with respect, and see every person as essential to the success of the organisation and what it is here for. Building and keeping a good culture is not dependent on a few people, it needs everyone working together. What you have done today is part of the process.

Taken from the Chair's speech at the all employee training day, May 2013

This style also characterised the Council, where new members echoed the experience of new employees – a welcoming, professional team, keen to assist. The Council, like the employees, regularly revisit the values and principles by which the organisation defined itself (see Figure 1 for an illustration of the importance of values to the Council's discussions in 2007).

Figure 1 Council strategic away day notes showing the importance of values, October 2007



Establishing the culture and values of the HCPC has played an important part in its success. Re-visiting what these are, and what they mean may seem unnecessary but without clarity and consensus on values, the health of any organisation is likely to suffer. Values need to underpin all aspects of the life of the organisation, from recruitment to delivery.

4. Stakeholder relationships

> Regulators are bound to upset their stakeholders. The important thing is not to upset all of them at the same time.

What the HCPC has sought to achieve over the years is a clear communication strategy with three primary aims – proactive engagement with stakeholders, creating and maintaining transparent access to all the regulatory activities of the HCPC, and involving stakeholders in the work of the organisation. Like the other directorates, the Communications team has been committed, creative and benefitted from consistent careful leadership. The sections below give some examples of how these primary aims have been achieved.

4.1 The public

The role of a professional regulator is to protect the public through setting and maintaining standards of practice for the regulated professions. The key stakeholders, therefore, are members of the public. However, 'the public' are not a single stakeholder group, and the HCPC has always taken the view that targeted communications and authentic involvement must define its work in this area. The Council and the Communications team gave careful consideration to these issues in the early years, and have learned through trial and error. There is no simple methodology and each context requires careful consideration and planning in order to achieve meaningful engagement and involvement. The Kennedy Report on the failures in care at Bristol Royal Infirmary first made reference to the importance of involvement of the public in professional regulation (Kennedy, 2001). The policy of promoting involvement has been consistent across governments ever since (DH, 2007, 2011). However, efforts to make this a reality across regulation in the UK have not been straightforward, and different regulators have approached this in very different ways. Beyond the obvious measures, such as lay membership on Councils and lay involvement in the regulatory activities of registration and fitness to practise work, there are a wide variety of ways to engage and involve people who use the services of registrants in regulation.

The HCPC has used market research, surveys, focus groups, targeted communications campaigns and specific research, working with user groups, experts by experience, voluntary sector organisations, and the media. All of these have been used to shape improvements in the HCPC's regulatory processes, including standards and guidance, written communications, web-based communications and changes to the online Register.

In 2005, the HCPC became active in the Joint Regulators Patient and Public Involvement Group. The aim of this group was to share good practice amongst the UK regulators. As part of this, the HCPC took the lead in organising a series of seminars for user groups. Three seminars were held between 2006 and 2009, for users of mental health services, people with acquired communication disabilities and one for older people. All were focused on discovering what more could be done by regulators to improve involvement of patients and the public. Users of services, advocacy groups and regulators attended these seminars. Two had video links to user groups in Glasgow (mental health) and Cardiff (older people forum). The outcomes included many practical suggestions for improving communications and making better use of networks and publications. One suggestion, which arose in many of the seminars as well as in other contexts, was a request for a single national complaints portal, with access to all the different regulatory bodies. The regulators are still discussing this option ten years on.

In October 2013 the HCPC ran a campaign in residential settings for older people. The aim was to increase awareness of the role of

regulation and the benefits of using a registered health professional amongst older people and their families, as well as with employers. The campaign included articles in magazines, posters and leaflets, radio broadcasts and talks at conferences, all with a focus on reaching older people using HCPC-registered professionals. Following the campaign, there was an increase in the number of referrals to the Fitness to Practise Department from residential care homes. This was an example of the targeted approach adopted by the HCPC and welcomed as a more effective means of involvement and engagement by users.

Proactive involvement of service users in revisions to the HCPC standards has improved significantly in the last five years, another example of how the HCPC has developed new approaches to engagement. In the early years, the majority of the work on standards was undertaken in collaboration with the professions, followed by a public consultation. These consultations rarely attracted much feedback from members of the public or from patients or users. More recently, the Policy and Standards Department has developed a new methodology for involvement, which includes commissioning research by user groups, funding advocacy organisations to run focus groups, and user representation on working groups set up to review changes to standards. This has been recognised by the Professional Standards Authority (PSA) and by regulators overseas as an example of good practice.

A final example of how the HCPC has developed its approach to involvement of users comes from its education function. In 2002, the HCPC's Education and Training Committee (ETC) had six lay members and twelve professional members (HCPC regulated twelve professions at this time). There were no lay visitors with a user perspective at this time. Visitors in education were recruited mainly from the professions and had to be educators in order to meet the criteria for selection. It was not until 2008 that the debate about whether lay visitors should be introduced to work alongside these professional visitors began in earnest. There was considerable opposition to the proposal at the ETC, so much so that the final decision to run a pilot project with lay visitors was reached nearly three years later. There are now 17 lay visitors, drawn from a wide range of backgrounds, many with personal experience of disability. They have made a significant difference to the way in which the HCPC approaches approval of programmes, with a clear focus on assessing how educational institutions are involving users of services in the design and delivery of programmes. The changes in this area were hugely enhanced by the experience of social work educators, who had a long experience of user involvement in education approvals by the time social workers in England became regulated by the HCPC.

4.2 The professions

4.2.1 Establishing HCPC 'listening events'

One of the ways in which the HCPC has established its relationships with professionals on its Register is through 'listening events'. Every year, approximately sixteen such events are held in eight locations throughout the UK. They involve sending invitations to all those on the Register who live within a 100 mile radius of the event. The programme always includes presentations on the HCPC and its work, and a question and answer session. The Chair and Chief Executive typically deliver the presentations, and the question and answer session always includes a panel made up of members of the Council and the Executive. Over the years, the events have become more interactive, and now include a workshop on a particular topic, such as 'professionalism'. To date, over 60,000 registrants have attended these sessions.

In the early years, the events were held in the large cities and towns of the UK, and some attracted 300–400 registrants. During the period before and after the introduction of the HCPC standards, the events were focused on giving professionals guidance on how to meet the standards. Over time, the events have been held in smaller towns, and in rural and remote locations throughout the UK. In November 2005, the HCPC held its first event via video link in Inverness, allowing registrants in the Orkneys, Shetland and Outer Hebrides to join the event.

When the HCPC took over the regulation of social workers in England, a large number of events exclusively for social workers were delivered along similar lines. Over 1,300 social workers attended, and strongly held views on the change from a single uni-professional regulator to a multi-professional regulator were often aired. These events were supported by Robert Templeton, a Council member and social worker, who played a key role in communicating the benefits of regulation by the HCPC as well as allaying fears about the impact of the loss of the General Social Care Council.

The importance of these events for professionals should not be underestimated. They became symbols of the organisation's ongoing commitment to engagement with the professions, and they remain a valuable source of information exchange at grassroots level. For a regulator to invest time and resources so consistently over time in engagement with those on its register was, at the time, unprecedented. To continue to deliver this programme year on year to many thousands of registrants has been an important reflection of the HCPC's approach.

Once the 'listening events' model was well established and the HCPC began to generate new research, the programme evolved into 'Meet the HCPC' events, which included an information update from the Chair and Chief Executive followed by a workshop. Typically, these workshops presented findings from research and then invited participants to discuss topics and share reflections. By 2013, some of these events were transmitted simultaneously online, with participants watching online and contributing remotely to the question and answer sessions.

4.2.2 Use of social media

The HCPC's use of social media began in 2012. There had been considerable debate up until that point about whether the use of social media was appropriate for a regulatory body, but by 2012 it became clear that these new forms of communication were, for many, a primary means of communicating. The HCPC was the first regulator to develop an App, first for the iPhone in 2012, and a year later for the Android phone. The original App allowed any user to check whether an individual was on the HCPC Register. Subsequently, more information about the HCPC's work was added. In 2013 a new App designed for registrants was developed, providing news and information about standards, fitness to practise and meetings. An HCPC YouTube channel, Facebook page and Twitter accounts were established around the same time, providing the organisation with multiple channels for communicating with its stakeholders.

4.3 Professional bodies

The HCPC's relationships with professional bodies have changed significantly over time. In the early days, many of them did not agree with the creation of a multi-professional regulator with one governing Council and integrated regulatory functions. The establishment of the HCPC precipitated significant change, as the disciplinary work of professional bodies was effectively taken from them. In addition, the approval of all education programmes became an entirely separate regulatory activity.

The HCPC's approach was to recognise the significant role played by the membership organisations. In the education sector, professional bodies continued to own the curriculum, and to influence the development of the profession. Some took on the role of 'critical friend' to the educators, planning joint visits with HCPC partners and providing expertise on changes to programme content. On the disciplinary side, those with union functions continued to represent and support members through HCPC fitness to practise proceedings. Over time, the organisations turned their focus away from regulatory functions and towards member services such as continuing professional development (CPD) online tools, post qualifying modules, and other forms of support and development.

Throughout this period, the professional bodies and regulator established a variety of meetings to ensure that the views and concerns of the professions were heard. Annual meetings between the Chairs and Chief Executives of the HCPC and the professional bodies were established, but the day-to-day exchanges occur at all levels and across all departments. The HCPC regularly attends conferences and events at the request of professional bodies. Targeted communication campaigns on the importance of using a registered professional, or the meaning of a protected title, or the importance of professionalism, have been welcomed.

It may be that the HCPC has avoided 'regulatory capture' by the professions because no one profession it regulates dominates the agenda. All professions are treated in the same way; there is no distinction in regulatory terms between the smaller and larger professions. All pay the same fee; all share the same standards and are subject to the same sanctions. There has always been a strong imperative to remain engaged with the professions and maintain regular contact. All member organisations have the same access to the regulator, regardless of size or perceived influence.

4.4 Educators

In the initial stages, when the HCPC was establishing quality assurance processes, there was a degree of skepticism amongst educators as to whether or not the HCPC could deliver on its new integrated approach. Under the previous regime, each profession had its own board, populated in the main by professionals and professional body executives. The new regime required the education providers to engage with one set of processes and standards for all programmes, something that was unfamiliar and untested. The ETC was populated by one member of each profession and six lay members, many of whom were drawn from the higher education sector and had senior roles. Professor John Harper and Professor Jeff Lucas were amongst the lay members who helped to shape the new way of working alongside experienced professional educators and academics like Eileen Thornton and Di Waller. It was not until 2006, when Abigail Gorringe was recruited to the role of Director of Education, that the Executive team had an established leader. This meant that in the first few years the Committee was heavily involved with designing systems and visiting programmes as well as at the more strategic level. The legislation determined that the ETC, through its panels, was responsible for the final approval of all programmes.

Throughout this period and beyond it, the HCPC ran a programme of events for educators each year, to ensure that there was an opportunity to discuss changes to education approvals. Once all the programmes were approved, the HCPC offered open-ended approval to universities and other training establishments. They had to submit annual monitoring information, and if major changes were planned, approval had to be obtained. This required a relationship of trust between

educators and regulator, and by and large this relationship has been maintained. Very few programmes have been found to avoid informing the HCPC of change and thus risk losing approval status. The approach was seen as light touch, or more recently 'right touch' regulation. Higher education is, by its nature, heavily audited internally as well as externally, and the HCPC's willingness to work alongside other quality assurance requirements and to avoid duplication of effort was seen as constructive by the sector. In all likelihood, this relationship helped to facilitate changes such as the introduction of a new mandatory standard on involving service users in education to be accepted by the academic community.

4.5 Employers

4.5.1 Employer events

Although the NHS employs many HCPC-registered professionals, there are large numbers who work outside it in social care, education, higher education and in a vast range of independent health and care organisations. The challenge of identifying and contacting employers and engaging with them has been significant. Like other large groups of stakeholders, the HCPC has been delivering tailored events for employers on an annual basis since the early years. These events are, in the main, attended by clinical and HR managers looking for information and guidance on dealing with complaints. The events provide updates and discussions of cases and scenarios, illustrating how local and national complaints processes are linked. In addition to events, employer surveys and other forums for gathering feedback have been used to ensure that there is good communication exchange.

4.5.2 Targeted campaigns – ambulance trusts

In 2010, following feedback from various employer events, the HCPC decided to set up meetings with all the ambulance trusts. The Director of Fitness to Practise attended all of these, as the focus was on sharing information about the fitness to practise process and how employers and the HCPC could work more closely. As a result of these, the rate of inappropriate paramedic referrals to the HCPC went down.

4.6 Unions

These meetings have been largely with union representatives involved in supporting their members through fitness to practise proceedings. Not surprisingly, therefore, they have not been happy with aspects of the HCPC's role and way of working. In 2014, the Fitness to Practise Partnership Forum was set up by the Director of Fitness to Practise and Director of Communications to facilitate further discussion. These are ongoing, and have been broadly welcomed by those who attend. Typically, the meetings have an agenda which is agreed in advance.

4.7 The Professional Standards Authority for Health and Social Care

The Professional Standards Authority for Health and Social Care is the government body established to provide oversight of the nine health and social care regulators in the UK. It was set up in 2002 by the NHS Reform and Health Care Professions Act as the Council for Healthcare Regulatory Excellence (CHRE). Its governing Council in the early days included the presidents of nine health regulatory bodies, along with an equal number of lay members.

The CHRE was set up to improve consistency and proportionality in regulatory outcomes. In order to achieve this, it conducted an annual performance review, by which it held the regulatory bodies to account against standards and published a report on performance.

CHRE's remit was also to ensure that the regulators' decisions about fitness to practise were not 'unduly lenient' in the eyes of the public. It therefore reviewed all fitness to practise decisions of the Councils. Bizarrely, this work was carried out by regulatory body presidents, although of course they were not permitted to review decisions made by their own regulatory body. They worked with lay members and members of the Executive team to review cases. Decisions by the regulator that were considered unduly lenient were referred to the High Court or Sheriff Court.

As government reforms to regulatory board structures developed (see also Governance section), the CHRE Council composition also changed, and presidents were no longer involved. Following the recommendations set out in the White Paper 'Equity and Excellence; Liberating the NHS (DH, 2010) the CHRE was re-named the Professional Standards Authority for Health and Social Care (PSA). It took on a number of new roles and developed existing ones, including oversight of the regulators, council appointments, commissioning research, auditing discrete areas of regulatory work and sharing good practice. In all of these endeavours, the HCPC has sought to work collaboratively with its oversight body. There has always been an inherent tension in the relationship, as the PSA have contested fitness to practise decisions (though rarely), and challenged the HCPC through the performance review process. The HCPC has always welcomed the existence of an oversight body, recognising the importance of public scrutiny. No doubt it will continue to disagree with the PSA on points of policy as well as regulatory practice, but always through constructive and collaborative ways of working.

4.8 Government

The HCPC has always taken its UK-wide remit seriously. One of the ways this has been evident over the years is through the regular liaison meetings with the health department in the four countries. These meetings would be held in Edinburgh, Belfast, Cardiff and Leeds, and would always involve the Chair, Chief Executive and, where relevant, members of the Executive Management team meeting with civil servants. Typical agendas would include updates on policy developments, workforce issues, education updates, as well as operational business such as upgrades to the registration system and handling of fitness to practise cases.

Meetings with parliamentarians would only take place when a particular policy, such as the regulation of an additional profession, emerged. The Chair and Chief Executive would ensure that politicians of all persuasion were briefed on the HCPC's position and made themselves available to answer specific questions. Following the publication of the White Paper of 2007 recommending that counsellors and psychotherapists be regulated by the HCPC, there was considerable interest amongst members of the House of Lords in the issues surrounding regulation. Several years later, the question of whether and how the adult social care workforce might be regulated also generated interest. The Law Commissions' major review of professional regulation and subsequent recommendations for reform were another important focal point for engagement with politicians (Law Commissions, 2014). In general, the HCPC has had more contact with members of the Lords than the Commons, and there have been more debates on professional regulation in the Upper House than in the Commons over the years.

Meetings with ministers would only take place at the request of the minister. The HCPC's view was that the regulator should only meet when required to do so. This usually occurred in connection with an additional profession coming into regulation by the HCPC.

5. Regulating additional professions

5.1 Government policy: 2001–09

There were a number of distinctive features of the legislation governing HCPC's functions – the Health Professions Order 2001, later re-named the Health and Social Work Professions Order 2001. The first was that it defined in law the workings of a multi-professional regulator, one which approached each profession in the same way.

A second important feature was its role in making recommendations about the regulation of further professions. The Health Act 1999 gave Parliament powers to regulate additional professions or make other changes to regulation and regulators using secondary legislation – known as a 'Section 60 Order'. Up until this time, the only option for any other health or care professions seeking statutory regulation was through primary legislation. The CPSM's legislation had allowed it to expand up to a maximum of twelve professions, each with its own uni-professional board, and it had done so under its own, more limited provisions. Article 3(17) of the Health Professions Order 2001 described how the new HCPC Council could make recommendations to the Secretary of State for Health and Scottish Ministers 'concerning any profession which in its opinion should be regulated pursuant to section 60(1) of the Health Act 1999'. Article 3(17) allowed the HCPC to make recommendations and to produce guidance to assist in making those recommendations.

As with all elements of the new legislation, the Council were quick to establish processes which would allow these powers to be exercised. The first version of the criteria were published in 2002 (see list below) and were based upon what were known as the nine criteria described by Lord Benson (Benson, 1992). Benson's thesis was that to be a professional meant operating within certain principles, all of which had a connection to serving the public interest (for a full discussion on this, see Guthrie and Waller, 2013). These were subsequently used across a range of sectors, and were by no means limited to the health sector.

Criteria for occupations considering applying for regulation by the HPC (2002, revised 2004)

1. Cover a discrete area of activity displaying some homogeneity
2. Apply a defined body of knowledge
3. Practise based on evidence of efficacy
4. Have at least one established professional body which accounts for a significant proportion of that occupational group
5. Operate a voluntary register
6. Have defined routes of entry to the profession
7. Have independently assessed entry qualifications
8. Have standards in relation to conduct, performance and ethics
9. Have fitness to practise procedures to enforce those standards
10. Be committed to continuous professional development (CPD)

The HCPC's criteria were widely discussed and distributed, and over the next nine years, enquiries were received from over 50 professional groups with an interest in statutory regulation. The Council recommended eleven professions to the Secretary of State under the provisions of Article 3(17).

5.2 Additional professions considered for regulation 2003–12

The Benson criteria were helpful in setting out the principles by which judgement could be made about eligibility. However, there were many different reasons for considering regulation, and not all new groups were regulated through the application process. The discourse has evolved over time, taking into account new theories and frameworks based more upon the risks posed by professions and their practise, and the impact of interventions on public safety (Sparrow, 2009, PSA, 2010).

5.2.1 Healthcare science professions and dance movement therapists

The first groups to be considered by the Council for regulation were the clinical perfusionists (September 2003) and clinical physiologists (October 2003). Clinical technologists and medical illustrators and maxillo facial professions were considered over the next two years. All of these groups were recommended for statutory regulation. Dance movement therapists submitted an application in March 2004 and the Council recommended them to the Secretary of State in December 2009. Music, drama and art therapists were already regulated by the HCPC.

5.2.2 Operating department practitioners

The first profession to be brought into statutory regulation by the HCPC were operating department practitioners (ODPs) in 2004. Work with the Department of Health (DH) and with the profession had begun soon after the HCPC was established. As with all new groups, the HCPC worked closely with its stakeholders to define the standards for ODPs. Once these were in draft form they were subject to a public consultation. During this time, a Section 60 order was drafted and consulted upon, and then subjected to the scrutiny of secondary legislation at the Holyrood and Westminster Parliaments. During this period, preparations to transfer the voluntary register from the Association of Operating Department Practitioners to the HCPC were underway. 8,000 ODPs were transferred on October 2004.

5.2.3 Hearing aid dispensers

The transfer of hearing aid dispensers to the HCPC Register was prompted largely by the 2005 Hampton review and its recommendations to reduce regulatory costs by merging non-departmental public bodies. At the time, hearing aid dispensers were regulated by the Hearing Aid Council (HAC), a small regulatory body with much higher costs per registrant than the HCPC, but with a wider remit for regulating companies as well as individuals. The demise of the HAC and the transfer of the regulation to the HCPC has been described in an excellent account by Sandra Verkuyten, the Chief Executive of the HAC, who was responsible for overseeing the transfer (Verkuyten, 2010). This document has since been used by a wide variety of organisations interested in the process of winding down a regulatory body, with all its operational and legal ramifications. As a result of careful planning and close working relationships between the Executive teams at the HCPC and the HAC, just over 1,500 hearing aid dispensers were transferred to the HCPC on 1 August 2010. As with other groups, new standards were developed in collaboration with the HAC and other stakeholders before undergoing a public consultation.

5.2.4 Herbal medicine, acupuncture and chinese herbal medicine

The regulation of Complementary and Alternative Medicine (CAM) practitioners in the UK has a long and complex history, and has been the subject of many government reports over the last three decades (Pitillo, 2008). The

HCPC became involved when a report from a working group chaired by Michael Pitillo recommended that these professions should be regulated by the HCPC. In September 2008, the Council considered the report and agreed that it would accept responsibility for regulation should the government choose to implement the Pitillo recommendation.

There were strongly held opposing views on the recommendation. On the one hand, there were those who referred to the significant risks posed by poor practise, versus those who felt that statutory regulation would give credibility to the CAM professions with little evidence of effectiveness. The Medicines Health Regulatory Authority was already responsible for approving certain herbal medicines in common use, and had experience in dealing with poor practise (MRHA, 2008). Their view was that statutory regulation was an important next step in order to protect the public from further harm. The professional bodies (for example, the Chinese Medical Council, the British Acupuncture Council, the National Institute of Medical Herbalists) broadly supported the recommendation and were for a period of time collaborating with the HCPC to develop more detailed plans on how statutory regulation might be introduced. This included addressing issues such as language competence and standards of education and training.

To date, the government has not pursued statutory regulation of these professions. In March 2015, the Walker report recommended that the professions should be encouraged to seek accreditation of their voluntary registers through the Professions Standards Authority scheme (Walker, 2015). The government have yet to respond to this report. The HCPC has not changed its position since the Council's decision of September 2008.

5.2.5 Psychologists

For psychologists, the journey into statutory regulation began many years before the HCPC. The British Psychological Society (BPS) had been exploring options for statutory regulation over several decades before it submitted its application to the HCPC. The Council recommended statutory regulation of psychologists to the Secretary of State in June 2004. In February 2007, the government published 'Trust, Assurance and Safety', a White Paper on reforms to regulation (DH, 2007). One of its recommendations was that psychologists, counsellors and psychotherapists should be regulated by the HCPC. The Council began its work with psychologists along the same lines as previously, setting up a working group, establishing draft standards and consulting on these. Psychologists, unlike other professions, had seven distinct domains of practice, and the standards of proficiency had to reflect these. In addition, the domains had different entry requirements. Other challenges included reaching agreement on the wording for the protected titles, and the fact that many psychologists worked outside the health arena. Despite the fact that the BPS had submitted its application to the Council in 2003, when the government's White Paper recommended that this be followed through, there was considerable debate within the professional body as to whether statutory regulation by the HCPC was the way forward. Discussions with ministers, debates in the House of Lords, and vociferous opposition from some took place alongside the lengthy preparations. A range of reasons were given by those who opposed HCPC regulation. For example, the HCPC was a health regulator, focused on the NHS, and had no experience of regulating in any other context. Second, it did not have the expertise to deal with the complexity of the discipline. Third, its standards were less rigorous than existing standards. There were also proposals for the creation of a new Psychological Professions Council as an

alternative to the HCPC. These and other objections and concerns about the HCPC model undoubtedly helped the organisation to develop and refine its rationale and communications. Many meetings took place, and all forms of communication were utilised in the work of engaging with the profession and with other stakeholders. Statutory regulation for psychologists was implemented in May 2009 and 15,536 psychologists were transferred to the HCPC Register. No one would look back on this process and suggest that it was straightforward. It was not. However, it would be fair to say that the profession has become fully integrated into the HCPC model and that relationships with the professional body are positive and constructive on all levels.

5.2.6 Counsellors and psychotherapists

Two other psychological professions were considered for regulation by the HCPC. In the White Paper 'Trust Assurance and Safety: the regulation of health professions in the 21st century' the following recommendations were outlined.

> 'The government is planning to introduce statutory regulation for…psychotherapists and counsellors…' (page 81)
>
> '…psychotherapists and counsellors will be regulated by the Health Professions Council, following that Council's rigorous process of assessing their regulatory needs and ensuring that its system is capable of accommodating them. This will be the first priority for future regulation.' (page 85)

As part of the preparations towards this, the Council set up a working group of stakeholders, known as a Professional Liaison Group or 'PLG', to consider how counsellors and psychotherapists might be regulated, in response to the clear statement of government policy outlined in the White Paper. In the summer of 2008, the HCPC issued a 'Call for Ideas' consultation, inviting stakeholders to submit their comments on the proposals. This consultation generated a high number of responses, and wide range of views on the proposals. In March 2009, a large stakeholder event was hosted by HCPC, providing further opportunities for debate. The working group comprised of members from the professional associations, from advocacy groups working on behalf of the public and those who used psychological services, academics, and practitioners. It was chaired by Di Waller, an art psychotherapist and member of the Council. As with all meetings, the group held its meetings in public, and there were many observers. By the time it concluded, the group had produced draft standards of proficiency – the first time that the many and disparate sub-disciplines within counselling and psychotherapy had come together to produce such a document. Throughout this period, there continued to be very public opposition from members of the profession, and consistently strong support for regulation from those representing the public. The HCPC was subject to a judicial review, but this was never concluded. A change of government in 2010 meant that the decision to bring counsellors and psychotherapists into statutory regulation was not followed through.

5.3 Government policy 2010–15

5.3.1 Regulating social workers in England

In July 2010 the government published 'Liberating the NHS: Report of the arm's-length bodies review', which outlined plans for re-structuring the work of a wide range of arms-length bodies. In it, the government announced that the regulation of social workers in England would transfer from the General Social Care Council (GSCC) to the HPC.

This announcement was not well received by the social work sector, for a wide variety of

reasons. The GSCC, as the statutory regulator of social workers in England, had only been in existence since 2003. The Social Work Reform Board, established to assist in taking forward reforms after the Baby Peter tragedy in London (Laming Report, 2009) was part way through its programme of reform, and there was also an ongoing major review of children's social work, led by Eileen Munro (DfE, 2011). Furthermore, social work across the UK had four separate regulators, and the government was proposing this change to social work regulation in England only. There were objections to the proposal on the grounds of cost (social workers were subsidised by the government and paid £30 per year, and the HCPC at the time had annual fees of £76), identity (the HCPC was considered a regulator of health professions with no expertise in social care), and expertise (the concept of a multi-professional regulator was not well understood or well received).

One of the most concentrated debates was around the re-naming of 'Health Professions Council' to reflect its new remit. The Council and Executive became engaged in debates about this; various proposals were put forward and polling was undertaken across the sector. In the end, the decision made by government was that the Council should be renamed the "Health and Care Professions Council". This decision required a huge operational change, as every external communication, signage, public display and web based communication had to be altered to reflect the new name. Alongside this external change, there were many hundreds of internal changes that had to be made to ensure that the organisation was ready for the transfer.

Although the organisation had experience of taking on additional professions and managing the process of transfer, this was a project on a different scale. At an operational level, the preparations for the transfer involved every member of the Executive Management Team in substantial additional work. At a strategic level, the Council held meetings with the Board of the GSCC, which were particularly challenging given the circumstances of the transfer. The Council continued in the habit of conducting its business in public, except when legal or contractual matters prevented this. In addition, members of the Council and Executive attended meetings of the Social Work Reform Board, the Munro Review, as well as meeting with the professional bodies, unions, educators. The HCPC ensured that it established good working relationships with the care councils in the other three countries of the UK. The Chair and Chief Executive were also members of a government sponsored group, the Social Work Oversight Group (SWOG). The Group was chaired by Harry Cayton, Chief Executive of the PSA. Other members included the Chair and Chief Executive of the GSCC, together with DH and Department for Education officials. Its role was to provide oversight of the transfer.

As with previous professions, the HCPC established new standards through a PLG, made up of representatives from the profession, as well as members of the Council. This group, chaired by lay Council member Jeff Lucas, produced draft standards of proficiency for social workers in England. There was no direct equivalent to these standards published by the GSCC. This was because the GSCC's legislation only allowed it to investigate complaints about conduct, not competence. In addition, the DH owned and published the requirements for social work education and training, with the GSCC responsible for approving programmes against those requirements. The draft standards were consulted on between July and November 2011, and the transfer of 88,000 social workers in England took place after the enactment of the legislation, on 1 August 2012.

5.3.2 Voluntary registers

The change of government in 2010 brought with it more than the radical review of arms-length bodies. A new policy for professional regulation in England began to emerge, culminating in the publication of a Command Paper entitled 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers' in 2011 (DH, 2011). This signalled the introduction of voluntary registers as an alternative to statutory regulation for health and care professions. The Command paper proposed that all nine professional regulators would be given the option to establish voluntary registers in addition to their existing powers. It further proposed that the PSA should establish an accreditation process for voluntary registers, adding to its role as the oversight body for professional regulation. These new policies were incorporated into the Health and Social Care Act in 2012.

The HCPC's view was that there were significant shortcomings in having a voluntary register held by a statutory regulator. These shortcomings were set out in the HCPC Position Paper, and were as follows (HCPC, 2012).

– Although an employer might make registration a condition of employment, there would be no legal compulsion for an individual to be registered.

– The regulator would be unable to demand information or compel witnesses as part of fitness to practise proceedings.

– A registrant removed from a voluntary register owing to serious concerns about their conduct or competence could remain in practise.

– There is potential for public confusion generally around the status of voluntary and statutory registers being held by the same organisation.

The HCPC also considered the costs of establishing voluntary registers and the challenges of ensuring that fees would be paid when registration was not mandatory. The Council concluded that it would not establish any voluntary schemes. To date, none of the nine professional regulators have opted to establish a voluntary register alongside their statutory registers.

Once the legislation was in place, the PSA introduced their accreditation scheme, allowing membership organisations and professional bodies to apply for accreditation. Funding is derived from an initial fee payable by the organisation, followed by an annual fee to maintain accreditation if all the criteria continue to be met.

5.3.3 Adult social care workers

One of the specific recommendations in the 2011 Command paper was that the DH would explore the scope for the HCPC 'to establish a voluntary register of [adult] social care workers [in England] by 2013'. This presented the HCPC with a particular challenge with regard to a new group. As regulation is a devolved issue, these proposals applied to England only. Scotland, Wales and Northern Ireland have all approached this in a different way, and have taken a decision to regulate this workforce.

In early 2012, the HCPC first became aware of a regulatory scheme in New South Wales Australia known as a 'negative licensing' or prohibition scheme. This scheme had been set up to address the lack of accountability amongst unregulated health practitioners. Some were individuals who had been struck off statutory registers and who began offering their services as alternative and complementary practitioners. Amongst the most notorious was the case of a dentist, Noel Campbell of the Hope Clinic, who began offering cures to cancer patients (Noel Campbell Inquiry Report, 2008). Others were care workers in residential homes, often serial offenders who moved from one employer to another without being held to

account (see the New South Wales Health Care Complaints Commission website). The scheme has since been expanded into other states and territories in Australia (AHMAC, 2013, 2014).

The HCPC began engaging with stakeholders in the sector, seeking views on the government's proposal that a voluntary register be established for adult social care workers in England. Employers, advocacy groups, voluntary sector organisations and users and carers were almost universally opposed to the creation of a voluntary scheme, on the grounds that there would be no incentive to join and no powers to hold to account serial offenders and others who were most likely to cause harm. There was one exception, a large employer who felt that they did not need a scheme of any kind, as their employees were not likely to abuse residents. The problem, as far as this employer was concerned, were the small, family-run residential homes who did not provide adequate training or support for their staff.

Much has been achieved across the sector in creating standards (Scotland Government standards (2010), Cavendish (2013), Skills for Health (2015) and in advocating better training, support and supervision for care workers. But from the evidence gathered from stakeholders, the problem of the small number of (often serial) offenders could only be addressed through statutory measures. Many in the sector advocated full statutory regulation as the best option. The HCPC proposed a statutory model based on the New South Wales scheme, advocating this as the most proportionate and cost effective way forward (see list below). The Council produced a position paper, outlining the estimated costs and draft legal framework, and proposed this as an alternative to a voluntary scheme (HCPC, 2012). It later renamed the scheme a 'suitability scheme' after discussions with stakeholders who disliked the use of the word 'negative' (HCPC, 2015).

A statutory code of conduct for adults care workers in England

A statutory code of conduct would be set for adult social care workers in England, based upon core principles such as respect for patients; confidentiality; infection control; honesty and integrity.

- Specific functions of that workforce could be protected by law.
- There would be no requirement for adult social care workers to be registered but a 'negative register' would be maintained of those who had been found unfit to practise as an adult social care worker.
- Employers would be expected to resolve low-level complaints, with an emphasis on re-training and remediation.
- Those cases involving more serious complaints, particularly where service users were placed at risk, would be reported to the regulator for investigation and, if appropriate, adjudication.
- The adjudication process would enable those unfit to practise as adult social care workers to be prevented from doing so by being included in the negative register.

HCPC Position Paper, December 2012

In addition to proposing the new scheme for adult social care workers, the HCPC advocated statutory regulation for Care Quality Commission-registered managers of care homes. Given their level of responsibility and influence on the culture of care homes, the HCPC considered that full statutory regulation was the most appropriate way forward for this group.

In the months that followed, there was support for the HCPC's proposals from parliamentarians in both Houses of the Westminster Parliament. Baroness Cumberlege, Conservative peer,

brought the scheme to the attention of the House of Lords in her debate on elder abuse on 14 May 2014 (Hansard, 14 May 2014). The report on the HCPC's Accountability session with the Health Select Committee lent its support to the proposals, recommending that 'as a first step to improve regulation in the sector, the government should publish plans for the implementation of the HCPC's proposals for a negative register. (HSC, 2014, Para 54). (See the web link under references for a full account of the session).

The Law Commissions' review of professional regulation supported the scheme, providing the government with draft legislation should it choose to bring such legislation to Parliament (Law Commissions 2014, Recommendation 31, and Part 7 p359).

Continuing stories of abuse in residential homes have kept the issue of regulation and accountability in this workforce at the forefront of public debate (see hcpcblogspot for details). The government have yet to make a decision on whether or not this form of regulation will be introduced. There are many who are hopeful that the draft Professional Accountability Bill will eventually bring this scheme into force and provide proportionate, robust protection for the public.

5.4 The role of professional regulation – proactive or reactive?

Professional reactions to statutory regulation differ hugely. There are some who see it as a straightjacket, a block on innovation and professional freedom. Others see it as a positive influence on educational and professional standards and a way of ensuring that those who use a professional title can be legally held to account. The traditional role of professional regulators has been to react to complaints, to spend time (and sometimes considerable) resource investigating complaints. In the last five years, there has been a move towards a more proactive engagement with the regulated professions and more research and dialogue around the reasons why practise might fall below what is expected. The HCPC has always had an interest in the proactive versus reactive debate, and has embraced the imperative to look closely at the ways in which regulation adds value to professional practise. This has included discussion about how to engage with the regulated professions (Zubin et al. 2015, Morrow et al. 2009, Redding et al. 2015). It has also meant that the HCPC has engaged with professions outside regulation both nationally and internationally, offered advice, support, challenge where governments, agencies, occupational or professional groups have sought it.

Successive governments across the UK have also approached statutory regulation in different ways. Regulation is a devolved matter, which means that the four countries of the UK do not necessarily agree on policy. Regulation of the adult social care workforce in 2015 is one example of this, where Scotland, Wales and Northern Ireland have chosen to regulate and England, to date, has not. Ideological positions have changed over the years, and an increasing focus on the resources required to bring a profession into statutory regulation and the fees required have influenced political thinking. From the beginning, the Council maintained a strong engagement with the governments of the UK on the issue of extending regulation to further groups, contributing to all the reviews, including Foster and Donaldson (DH, 2006), Pitillo (2008), Livingston (2008), Law Commission (2014), and Walker (2015) and giving careful consideration to their recommendations. The HCPC's Accountability session at Health Select Committee in January 2014 generated further debate (HSC, 2014). Although the emphasis has changed and the evidence base has grown, the HCPC's position has remained consistent – low cost, multi professional statutory regulation offers the best model for ensuring that professionals are held to account and the public are protected.

6. Governance

> "Governance is an unfolding, always incomplete phenomenon, driven by soft realms of thought."
> Meuller, 1981

The HCPC had a clear governance framework set out in its legislation. As governments changed, and public scrutiny intensified, so too did the policy on the governance of regulatory bodies. Successive reforms aimed to create more 'board like' councils, smaller in size and with wholly appointed members. Elected members who saw themselves as representing a particular professional group, had been disruptive influences on many of the regulatory body councils during this period. The HCPC was no exception, although it experienced relatively little of this. Structural reform was inevitable.

6.1 The re-structuring of Council, 2002–14

In 2001, the Shadow Council was made up of 13 elected registrants and their professional alternates, and 12 appointed lay members. This difference in numbers was because Norma Brook, as a registrant Chair of HCPC and physiotherapist, created an additional place for another physiotherapist. These 38 members populated eight committees, along with a small number of individuals who were appointed to particular roles, such as the Medical member of the Health Committee. In July 2006, when Norma Brook stood down as Chair, Anna van der Gaag was elected by the Council and continued in this role until June 2015, the first year as an elected Chair and later as appointed Chair.

Following the publication of the 2007 White Paper on reforms to regulation, the government made it clear that it favoured smaller, appointed regulatory councils to large, elected or partially elected ones. The Council had already begun to discuss the challenges of large councils with growing numbers of elected members. Other regulatory bodies were also making plans for re-structuring. There were widely differing views on whether the HCPC should agree to reduce in size to a smaller council, given that it was multi-professional and therefore different from all other regulatory bodies in the UK. Some members were strongly in favour of the status quo, although almost all saw the advantages of wholly appointed boards. Others argued for a council of no less than 24. After long and challenging meetings, the Council agreed to what was called a 'Big Bang' solution – the creation of a new, wholly appointed council of 20 members, ten lay and ten professional members. This meant that all the current members, including the Chair, would stand down. Some would seek appointment, and others would retire. There should be no more than one registrant from each profession, and the range of professions appointed would need to be an important part of 'keeping all the professions on board'. Furthermore, the Council agreed that there should be generic, governance skills required for all, and a range of specific skills amongst both lay and professional members.

The 'Big Bang' decision was brave and far-sighted. Those who argued for a wholly appointed, new Council were taking a principled position, knowing that a competitive process with existing members competing against one another and against other candidates would have to follow.

The current Chair was appointed through a competitive process in July 2009 and the new Council was in place by September 2009. It continued to work to the same agenda until after the general election.

The general election of 2010 brought a new Conservative-Liberal Democrat coalition government to power, and with it came some changes to health and care professional regulation. The coalition had much less of an appetite for extending professional regulation to new groups, but it continued to press for further reforms to the governance structures. The Command paper 'Enabling Excellence' (DH, 2011) led to further restructuring of the councils, which began with the Nursing and Midwifery Council, the General Dental Council, the General Medical Council and eventually to all the other regulatory bodies. The councils were further reduced to twelve member councils between 2011–13. The HCPC was the last to be re-structured, on the grounds that it was orchestrating the transfer of social workers in England to the HCPC Register. The HCPC re-structure was therefore not completed until January 2014.

As a result of the success of the Big Bang decision, there was much less anxiety internally about the move to a smaller Council. The Chair was, once more, involved in the recruitment of new members, which provided a degree of continuity to the restructure. The coalition had abolished the Appointments Commission in its cull of non-departmental public bodies by this time. As a result, the HCPC Secretariat ran the recruitment process, with oversight from the Professional Standards Authority.

6.2 Meetings

Council and Committee meetings were held in public. This meant that any person could attend the meeting and listen to the debates. Papers were posted on the website a week before meetings. A small number of agenda items were discussed in private at the end of the public meeting, and the reasons for this were always clearly articulated in the papers. Examples included decisions of a legal nature, or matters relating to employment.

As in many other areas of the work, the HCPC council process benefited hugely from the expertise of its Legal Counsel, Jonathan Bracken. Considerable time was invested in drafting standing orders and the scheme of delegation, which was rigorously adhered to. These were modified over time, but they played a central role in ensuring consistency in the conduct of meetings and the way in which decisions were made.

In later years, the Council had more reflective discussions about its interpersonal ground rules for meetings – allowing others to speak, not interrupting and not revisiting decisions once they had been formally agreed. There were virtually no instances where the Council ever took a vote. Decisions were reached by consensus.

There were also regular opportunities for informal as well as formal discussion. Initially, there was one annual off-site strategic 'away day', attended by Council and alternate members as well as the Executive team. From 2007 onwards, there were additional workshops at other times. From 2014, the Council agenda included a final item called 'meeting evaluation' during which members offered their reflections on the meeting, and whether there were any aspects that could have been improved upon.

6.3 Council member recruitment

Between 2007 and 2014, there were three recruitment exercises for Council members. As with all public appointments, all members were approved by the Privy Council and appointed on fixed terms of office. During the first campaign, the Appointments Commission worked closely with the HCPC on the competencies required and the recruitment process was largely theirs. In the

later campaigns, there continued to be at least one independent assessor on the selection panel, with experience of recruitment to public bodies. Following the abolition of the Appointments Commission in 2011, the HCPC assumed responsibility for the appointments process, and was accountable to the PSA as its new oversight body for appointments (DH, 2010). The HCPC took the opportunity to modify the selection process to ensure there was more in-depth assessment of the interpersonal skills and competencies required. Candidates were invited to present on a topic, take part in a one-to-one interview and participate in a group discussion. This multi-layered model allowed the panel to assess values as well as competencies. What the panel looked for was an ability to work in a group context, to listen, to be reflective, to show an understanding of the ground rules of debate, as well as the analytical skills and experience to work as a non-executive. The other important element of the selection process was assessing understanding of the principles of equality and diversity and how they played out in the HCPC context.

The other element of the selection process was that the panel used a skills matrix to ensure that the right mix of expertise was always at the table. This took account of the skills required of all members, for example governance experience, and those required of individual members, such as ensuring that members had educational, advocacy, finance, social care, health and educational experience.

6.4 Performance review process

Responsibility for oversight of member performance lay with the Chair. The Order set out the circumstances in which a member could be removed (Schedule 1, Part 1 9 (2)), and this involved bringing the decision to the Council. In the years when there were appointed and elected members, the Chair was only required to write a report to the Appointments Commission on appointed lay members as they became eligible for re-appointment. Once all members were appointed, this process applied to all.

Like all of HCPC's processes, the content of the internal annual performance review evolved over the years. From 2007 onwards, the review comprised three parts. A self-evaluation against competencies, an evaluation of the Chair by members, and an organisational 'health check' – an opportunity for members to comment on the organisation and how well (or badly) they felt the Executive and Council were working together. The first part – the self evaluation, included identifying training and development needs for the following year. Each Council member met with the Chair to discuss the completed review forms. This discussion centred on personal reflections on performance, training needs and feedback on the working relationships with the Executive. The latter part of the discussion was collated by the Chair (anonymously) and formed the basis of discussion with the Executive team. The themes from this part of the review were also brought to the Council for discussion.

In addition to the work carried out by the Council member and Chair, the Secretariat collated all scores on the Chair's performance in an anonymous format, and prepared a paper that was later discussed in public at Council.

The overall approach to performance review was premised on rigorous self evaluation, both for the members and the Chair. Besides this annual review, the Chair and members had regular conversations as and

when they were required, and new members had an additional six-monthly discussion with the Chair. The philosophy was that it was always better to create opportunities for discussion than to disengage.

This philosophy carried through into relationships at the Council table. Perhaps the more nuanced level of analysis here lies not in the development of structures but in the soft realms of governance, paying close attention to the internal politics and evolving nature of relationships within a diverse group. Issues of status and control and conflicts of interest will arise whoever and whatever structures are in place. Looking back on the last nine years, there are a number of important constructs that have shaped the Council and its way of working.

6.5 Equals around the table

There is little doubt that the 'success' of governance was also due to HCPC's multi-professional origins, and the fact that no one profession dominated the agenda. There were, in the early years, some divisions between lay and professional members, but these did not persist, perhaps because the Council was focused on creating robust, multi-professional standards and on external issues such as extending regulation to new groups. These were large, unifying challenges.

However, there was another important element. One of the defining features of the governance model which evolved at the HCPC centred on equality. The non-executives and executives began to see themselves as 'equals around the table'. Each had a contribution to make and expertise to bring, but there was no sense of hierarchy, and no place for status driven contributions. On one memorable occasion, the Council and alternate members (numbering 38) were invited by the Chair to sit at one table for an off-site Council meeting, something which helped to dispel any sense that the alternates were not valued for their contribution. The result was that there were fewer and fewer 'them and us' conversations over time, decisions were arrived at in a business like way, and meetings did not encourage personalised or factious debates. This did not mean that there was not strong disagreement at the table. It did mean that the Council members and the Executive team began to establish a 'primus inter pares' relationship in which the Executive team prepared and presented papers and the Council reviewed and commented on them, in most instances coming to the same conclusions about the way forward.

Amongst the agreed ground rules and reasons for the success of this model were that, from 2006 onwards, no meetings of the Council members took place without the executive members present. This included the strategic 'away days' and workshops. This was not always the way things happened. In 2004–06, there were a number of meetings without the Executive present, and these always resulted in erosion of mutual trust, mainly between those in the meetings and those excluded from it. These meetings also had a tendency to create sub-groups and factions within the Council membership itself, sometimes lay versus professional members, sometimes UK country divisions, and sometimes divisions based around strongly held views on a particular topic.

6.6 Board effectiveness

As described above, a number of processes were put in place to monitor individual and board performance over the years. Monitoring does not of itself lead to greater effectiveness of course. In 'Boards that make a Difference' (Carver, 2006) John Carver outlines the common practises, which become a 'drain on Board effectiveness' (p18). These include the following.

1. **Time spent on the trivial**
   Procurement decisions – which tables and chairs to purchase for the office.

2. **Short term bias / self interest**
   Discussions on board member's travel expenses, or personal 'blind' spots about conflicts of interest.

3. **Reactive stance**
   A lack of regular focus on future proofing, looking ahead at what new policy might impact on regulation.

4. **Reviewing, rehearsing, re-doing**
   A tendency to revise sentences or words in documents at board meetings, or asking for re-run of decisions made.

5. **Leaky accountability**
   Board members who circumvent the Chief Executive outside meetings, because they think other members of the Executive will be more malleable.

6. **Diffuse authority**
   This occurs when there is a lack of clarity over who has the authority to make a decision, for example if the scheme of delegation is unclear or not fully agreed to.

7. **Overload**
   Too much business is brought to the board, resulting in ineffective decision making, lack of attention to important details.

All of these have been experienced at the HCPC Council table. No team of people involved in governance can be exempt. What marks the HCPC approach is an ongoing commitment to transparency and openness, a willingness to address these common practices as they arise, to create opportunities for reflection on board performance, and where necessary to re-articulate ground rules and to challenge where this is required.

Carver goes on to articulate the five qualifications for good governance, which have been used regularly at HCPC strategic away days as a starting point for reflection and review. Carver suggests that successful strategic leadership can only come when these qualifications are met (see list below). They have certainly helped to shape the recruitment of new members at the HCPC as well as maintain focus on the Council.

Five qualifications for good governance

1. A commitment to the ownership and to the organisation's area of endeavor.

2. A propensity for thinking in terms of systems and context.

3. An ability and eagerness to deal with values, vision and the long term.

4. An ability to participate assertively in debate.

5. A willingness to delegate, to allow others to make decisions.

From Carver, 2006, p296

There is another element of Carver's thinking, which has influenced the HCPC's Council and its governance practices over the last nine years. This has been an ongoing exploration of the purpose and values of the organisation. Carver's notion that good governance starts with clarity of purpose and fidelity to values has been hugely influential. As new members joined the Council, it was important to re-visit these. "Excellence can be lost through the influx of new members, who have not agonized through the process of improvement". This observation does not suggest that refreshment of membership is not a positive thing in governance terms, but, for new organisations in particular, there is a need to recognise how much work has been done in the crucial establishment phase, especially when this has been controversial. Reaching a

common understanding of the purpose of the organisation and its fundamental values is usually a constructive way to re-establish consensus on what the Council is there to contribute, and what it delegates to the Executive team.

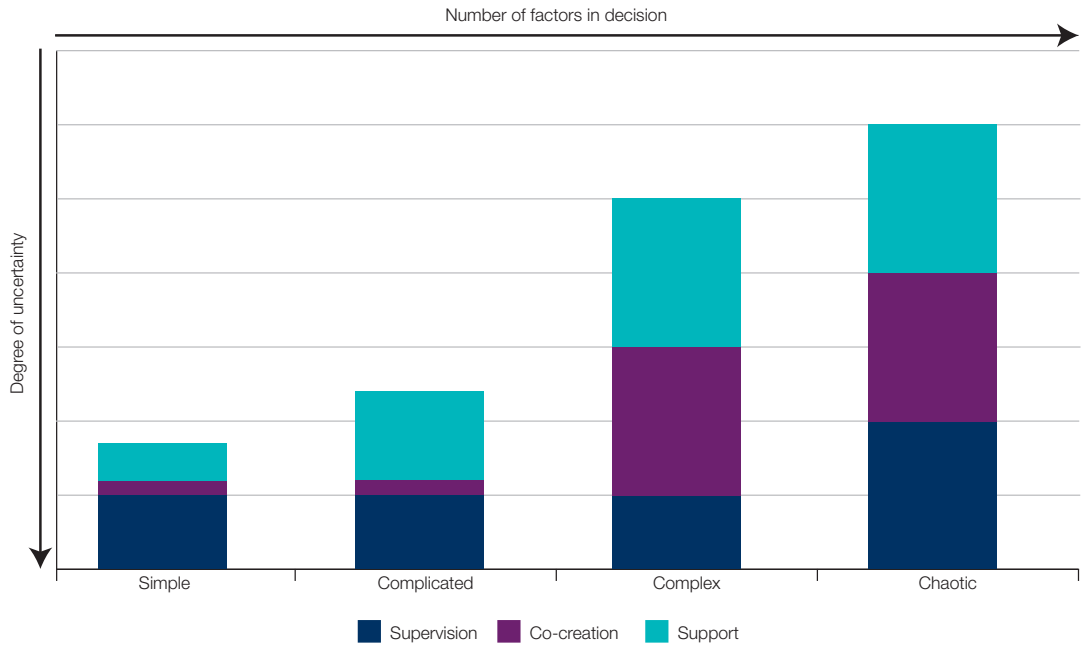
In summary, these key ingredients have facilitated board effectiveness at the HCPC.

- Maintaining clarity of purpose
- Evidence-informed decision making
- Commitment to transparency
- Absence of regulatory capture – no one profession dominates
- Modern legislation
- Good working relationships with government departments
- A strong executive team and an efficient and engaged secretariat

6.7 The importance of context in governance

There have been many other influences, both theoretical and practical, on the discussions on governance. Perhaps the most enduring has been from the work of John Carver. Another has come from Crossin's exploration of boards and their contribution to strategic decision making (Crossin, 2013). He proposes that boards should be involved in three 'strategic' activities with the executive; co-creation, supervision and support for the executive. The impact of context on these activities is significant. For example, if a board finds itself faced with an unpredicted and potentially volatile (or in Crossin's terms 'chaotic') context, such as sudden regulatory failure, then the board will need to provide higher levels of support and supervision to the executive than for example when the organisation is operating under 'business as usual' circumstances. The higher the degree of uncertainty, and the more factors that need to be taken into account, the more 'chaotic' the context, and the board must adjust its level and type of involvement (see Figure 2).

Figure 2 The importance of context in decision making (Crossin, 2013)



One of the common failures of governance is that boards have little or no ability to make such adjustments or to be sufficiently self aware of the varying levels of involvement required by the executive at different times. Another is that individual members of a board may have very different expectations of what strategy is, and this needs to be explored regularly as new members join. There is rarely a successful outcome in a strategic workshop until there has been a full exploration of the different meanings attributed to 'strategy' itself. This is an exercise that needs to be repeated, not once but many times in the lifetime of a board.

6.8 Organisational health

A final reflection on the underpinnings of governance at the HCPC. In its discussions, the Council explored the notion that organisational health depends in equal measure upon good processes and strong working relationships. In all these workshops, the Council has endeavoured to review both, and to adjust where necessary. Lencioni (2012) observed that an organisation is 'healthy' when its management, operations, strategy and culture fit together. 'The signs of a healthy organisation include minimal internal politics and confusion, high degrees of morale and productivity and low turnover amongst employees' (p5). He goes on to suggest that there is nothing more important than a regular review of the 'health' of an organisation. This applies as much to governance as to any other element. Signs of 'unhealthy' governance start with a fraying of trust between executive and non-executive, teased apart by assumptions of status and a lack of a shared understanding about purpose.

7. Developing the evidence base of regulation

7.1 Becoming an evidence-based regulator

In October 2012, Ron Paterson, New Zealand's former Health and Disability Commissioner observed that 'an effective regulator brings evidence to bear on all its activities' (Paterson, 2012). In September 2014, Joanna Flynn, Chair of the Australian Medical Board, challenged an international audience of health professional regulators to focus on evaluating the effectiveness of regulation. She suggested that regulators need to become regulatory scientists when "to date we have been regulatory philosophers" (Flynn, 2014). These comments reflect a growing focus on the evidence base of regulation, much welcomed by those who had been investing in this agenda for some time (Short and McDonald, 2012, HCPC, 2009). Similarly, Walshe and Archer, in an editorial in the British Medical Journal, stressed the importance of bringing more research evidence to bear on regulatory activities. The article cited the HCPC as an example of a regulator already undertaking a "substantial programme of research" (Walshe and Archer, 2014).

The seeds of the HCPC's interest in developing the evidence base of regulation began very early in its history. Much like the narrative on culture and values, there was very little explicit debate on the use of research evidence in the first few years, as the organisation focused on establishing its regulatory processes and functions. However, from 2002 onwards, the HCPC was committed to creating a transparent approach to its management information. Meetings of the Council and committees were furnished with detailed reports from the departments, and information on trends in the registration, fitness to practise and education functions were routinely accessible on the website. In addition, the management reports from each director give regular updates on the operational functions such as finance, human resources, IT, communications, and business process improvements such as the quality management systems and BSI audits. These datasets were all in the public domain, and over the years have proved a rich source of information for many researchers and policy makers outside the organisation as well as inside it. The development of this culture of routine reporting contrasted greatly with the HCPC's predecessor, the Council for Professions Supplementary to Medicine (CPSM), where information was not forthcoming and nor was it in the public domain.

From early on, the Communications Department was actively collecting data via market research initiatives, some internal and others external. Regular polling of public and professional awareness of the HCPC and its role was undertaken, in addition to more discrete pieces of work aimed at testing the views of stakeholders. All of these results were brought to the Council and were an important influence on the ways in which the organisation improved its processes over time.

7.1.1 External recognition

It was not long before the quality of the information that the HCPC made available began to be recognised externally. In its 2007–8 performance review of all health regulators, CHRE commended the HCPC on "the quality of its management information and data collection" (CHRE, 2008, p.30) and described the HCPC as "a well organised regulator, clearly committed to constantly improving the efficiency of its performance" In 2012–13, the Professional Standards Authority (formally CHRE) commended the HCPC for its evidence-based approach to decision making on continuing fitness to practise (PSA, 2013, p.127). The National Audit Office carried out an independent organisational health check on the HCPC during 2008. It highlighted the HCPC's record of achievement in its project work and its willingness to recruit external expertise where

appropriate – two important factors which contributed to its success (NAO, 2008).

It was around this time that the organisation moved to a new focus on commissioning external research work as well as continuing to undertake routine analysis. By this time, the majority of the regulatory processes were established. The HCPC began to think about initiatives that would contribute to the evidence base of health regulation more widely. The continuous business improvement culture, in which business processes were reviewed and evaluated clearly helped in establishing a platform for this. In addition, academics and policy makers recognised the rich source of data held at the HCPC, and many approached the organisation for help with their research.

7.1.2 Commissioning research

Jackie Gulland from the University of Stirling undertook the first piece of commissioned work in 2008. This was a review of the existing research on complaints handling in public services. Not surprisingly, the report concluded that there was a lack of research and analysis in this area and an even smaller evidence base relating to the professions regulated by the HCPC (Gulland, 2008). Gulland made a number of recommendations for further research, including the need to develop greater understanding of the complaints process from the complainants perspective. These recommendations were taken forward by the Director of Fitness to Practise, Kelly Holder (nee Johnson) and led to a series of commissioned projects over the next few years on complaints, complaints handling, alternate dispute resolution, public perceptions and professional experience (Mori, 2010, Irvine et al, 2011, Moore et al, 2013). All of these had a direct impact on the way the HCPC delivered regulation. For example the Ipsos Mori research recommended changes to the information the HCPC provided on the fitness to practise process. This resulted in the production of a short film explaining the process in detail, an Easy Read version of the leaflet on how to make a complaint and eventually revisions of all the other information leaflets (available on the HCPC website).
The Irvine review, a comprehensive review of existing literature on the use of alternate dispute resolution recommended that the HCPC establish a pilot project to test the use and value of mediation in a regulatory context (Irvine et al, 2011). The HCPC was the first to introduce such a scheme into the regulatory context. Since then, others have developed forms of ADR, recognising that there are concerns that are best handled in this way.

There were of course significant external influences on the HCPC research and policy agenda. The landscape of regulation was changing, not least in response to the Shipman Inquiry, and the Donaldson and Foster Reviews (DH, 2006). In February 2007, the government published a White Paper on reforms to regulation (DH, 2007). Amongst the recommendations, 'Trust, Assurance and Safety' (DH, 2007) stated that 'all health professionals should be revalidated' (p37). There was very little detail on how or what this might mean for the regulators. The HCPC's response was to establish a working group with a wide membership to look at the evidence base for this proposal, discussing big topics such as the differences between quality improvement and quality control in regulation, how risks might be measured, and the extent to which proportionality and cost considerations needed to be taken into account in policy making. In 2009, it published a report entitled 'Continuing Fitness to Practise – Towards an evidence-based approach to revalidation.' This was an important report, which set out the HCPC's view that there was as yet insufficient evidence for the implementation of the proposed revalidation policy. There were two key reasons for this. Unlike doctors at the time, HCPC registrants were already required to meet mandatory standards on continuing professional development and to demonstrate that they kept their knowledge and skills up to date. Second,

the report highlighted the fact that the majority of complaints to the HCPC were about conduct, not technical competence, and that research to explore this further should inform any future policy (HCPC fitness to practise annual reports 2003–8). Moreover, if failures in conduct and professionalism were causal factors in the majority of complaints, then additional measures to check competence might not be the most proportionate or appropriate way forward. Regulators in Ontario and Quebec, Canada, have reached similar conculsions. For more information see the HCPC report on the visit to Ontario regulators (HCPC, 2010) and the revalidation project update (HCPC, 2009).

Following the publication of its report in 2009 the HCPC went on to commission a five-year programme of research on professionalism, funded by the Department of Health (DH). The first study looked at perceptions of professionalism amongst students, educators and registrants, and the second, longitudinal study looked at methods for measuring professionalism (Morrow et al, 2009). The DH later provided additional funding for a study examining the costs and benefits of the HCPC's audit of continuing professional development (CPD). All of these studies were widely disseminated amongst the HCPC's stakeholders, and became the basis for discussions about the nature of professional practise, and the reasons why conduct and ethics were so central. The Chief Health Professions Officer for England, Karen Middleton, used the research as a basis for 'the Big Conversation,' a joint project to promote conversations about professionalism amongst practitioners following the publication of the Francis report on the Mid Staffordshire NHS Trust. The Scottish Government initiative on professionalism used the report as a reference point in its recommendations (Scottish Government, 2012), Robert Gordon University in Aberdeen used the research to generate discussion about professional and unprofessional behaviour on its Employability module – an initiative that looks at ways to enhance graduate employability. These were just some of the examples of the ways in which the report was used by others to influence thinking.

Like the CPD standards themselves, the HCPC's work on professionalism placed great emphasis on the importance of self awareness and reflection on practice. The professional bodies embraced this agenda, many of them working closely with the HCPC at this time.

7.1.3 The HCPC research strategy

In January 2009, the Council approved the HCPC's first research strategy. This brought together the strands of work that had been developing across departments and as a result of external influences on regulation. Linked to the Council's strategic objectives, it articulated the organisation's commitment to building the evidence base of regulation and provided the framework for a coordinated approach to research. In addition, departmental objectives and workplans made explicit links to the research strategy.

Key objectives of the HCPC research strategy

1. Undertake research and consultation into all aspects of the HPC's current regulatory processes.
2. Undertake research into risk based revalidation and CPD monitoring.
3. Engender greater understanding of risk based approaches to regulation.
4. Ensuring that research reports are widely disseminated.
5. Using seminars to discuss research findings with stakeholders.
6. Ensuring that HPC research findings are taken into account in the development of wider regulatory policies.

From HPC research strategy, 2009

Since the Gulland review, the HCPC has published 15 research reports on a wide range of topics, all of which have had an impact on the HCPC's way of working, bringing new insights and improvements to the way regulation is delivered.

There has been increasing interest in this work amongst regulators and academics in other jurisdictions. Stephanie Short, Convenor of HealthGov Australia, a group of academics and regulators, commended the HCPC for its evidence-based approach and its unique contribution to research in regulation (Short and McDonald, 2012). The HCPC has presented its research at conferences in South Africa, Singapore, Malaysia, Japan, Canada, within the EU, the US and Australia.

In 2013 and 2015, the HCPC hosted an international conference on research in regulation, attracting delegates from over 50 agencies across 20 jurisdictions. These were designed to coincide with a conference of US regulators, the Council on Licensure, Enforcement and Regulation (CLEAR). These events have created valuable networks and new initiatives across borders, contributing to the research base of regulation worldwide.

So what has been the value of embedding a strategy on research into the overall strategy of the organisation? First, it has created a coordinated approach, one in which the commissioning and oversight of projects and dissemination of findings is consistent, coherent and robust. Second, it has established the HCPC internationally as an evidence-informed regulator, committed to making decisions based on evidence and ensuring that changes to policy are always made with reference to evidence. Third, it has helped to build credibility and confidence amongst stakeholders, and has generated new interest and involvement from academics. Finally, it has produced new research into areas of professional regulation.

7.2 Two examples of how an evidence informed approach influenced HCPC policy and practise

7.2.1 Social work and student fitness to practise: finding a proportionate way forward

During preparations for the transfer of social workers in England to the HCPC, one of the issues that gave cause for concern was the regulation of social work students. The existing regulator, the General Social Care Council (GSCC), held a register of approximately 17,500 social work students, in line with the other social work regulators in Scotland, Wales and Northern Ireland. In contrast, the HCPC did not hold a student register. Instead, the HCPC regulated the fitness to practise of students through the standards of education and training and the approval of education and training programmes.

Between November 2011 and March 2012 the HCPC ran a consultation on whether or not a student register for social workers in England should be held by the HCPC, and whether or not a student register should exist for the other 15 professions. The majority of those who responded from the social work community thought that registration of social work students in England should continue. Some suggested that there were large numbers of students who were not fit to practise. Registration was seen as helpful in providing a 'safety net', which ensured that consistent decisions were made about the suitability and conduct of students. This was often considered useful in providing additional reassurance to employers accepting students on practice placements. In contrast, respondents from the other 15 professions regulated did not think a student register was appropriate, considering that these issues were best managed by education providers in accordance with the standards, assured through the programme approval arrangements. It was clear from the

consultation that whatever stakeholders' views on registration, all wanted the same outcome – students who understood the professional responsibilities expected of them and who were fit to practise, but there were widely differing views on how this was best achieved.

In order to assist with this decision, the HCPC commissioned an independent review of the literature on student registration and student fitness to practise (Boak, et al 2012). The review found that that student registers worldwide were the exception, rather than the norm in professional regulation. Other mechanisms, such as robust standards for educators and placement supervisors, well executed student fitness to practise processes, and holding students to account through standards and guidance on conduct were more commonly used. The review also highlighted the need to educate students about their responsibilities as professionals in training.

The HCPC took the evidence from the review and the results of the consultation, and concluded that the evidence base for the creation of a student register would not support the introduction of a student register. However, in its discussions, the Council were mindful of the potential impact that not registering social work students might have on social work education providers and employers. The Council therefore decided that it would introduce interim arrangements over a two to three year period whilst its approval of social work programmes took place. It established a social work student (England) suitability scheme, based on the principles of negative registration (outlined in Chapter 5 (p28). The key features of the scheme were as follows;

- There was no register of all social work students in England.
- There was a mechanism for referral to HPC where:
  - in exceptional circumstances, an education provider required an independent decision on whether an applicant was of suitable character to be admitted to a programme;
  - a student had been removed from a programme or had withdrawn from a programme following a complaint; and
  - an education provider had not dealt with a credible complaint appropriately.
- Students who had complaints upheld via the scheme could be placed on a list, which would prevent them from being admitted to, or participating in, a social work programme.

The scheme had several benefits. It provided the 'safety net' that social work stakeholders had said was necessary. It allowed educators, employers, colleagues and members of the public, to refer their concerns to the regulator during the transition to HCPC standards. It was proportionate, in that it was a scheme only for those students and prospective students who were a cause for concern. It sent a clear message to educators that they were responsible for ensuring that student fitness to practise was managed and quality assured according to HCPC standards.

Over the next three years, 58 students were referred to the scheme. One student was placed on the list of those who were prohibited from continuing with or entering a new social work programme.

Without the independent research evidence demonstrating best practise from elsewhere in the world, the HCPC would have had much greater difficulty implementing this policy. The student suitability scheme was a path of compromise that ultimately contributed to the evidence base.

7.2.2 Involving service users and carers in research

Although the HCPC was active in undertaking surveys with patients and the public from the outset, it did not begin to commission research led by service users until years later. One example of this, commended by the PSA in its 2013–14 Performance Review, was the research on the standards of conduct, performance and ethics. The HCPC's Director of Policy and Standards, Michael Guthrie, designed and led this work (HCPC Committee paper, 2011). It included commissioning qualitative research with users and carers, surveys with employers and professionals, and workshops led by service users. The outcomes of these projects were fed into the revisions to the standards and resulted in significant changes. For example, the revised standards strengthened the HCPC requirements on raising and escalating concerns, placed more emphasis on partnership with patients and service users, and foregrounded the importance of attributes such as empathy and compassion.

Within the education function, the HCPC commissioned a number of pieces of work on user involvement in regulation. One was a project undertaken by disabled students and educators, who reviewed the HCPC's document, A disabled persons guide to becoming a health professional, and made recommendations for its re-design. The use of narrative to illustrate particular circumstances was utilised extensively in the re-design, and made the document more accessible as well as more contemporary. The HCPC also commissioned a comprehensive review of user involvement in the design and delivery of education programmes. It identified the components of good practise, exploring the benefits and challenges of involvement in education and training settings (Chambers and Hickey, 2012). This report made an important contribution to the HCPC's decision to mandate user involvement in the approval of all programmes.

8. International perspectives

Professional regulation is a global exercise. Like other industries, establishing systems and relationships that allow the efficient transfer of information is critical. If a physiotherapist in one country is sanctioned, and decides to move to another country, there need to be mechanisms in place to ensure that the regulator in that country is aware of the sanctions and can act accordingly. For this reason alone, it is important that regulators establish networks, and work together in the interests of the public.

There is also value in sharing good practice and research evidence. This has become an increasing focus at international conferences of regulators. There are currently three major platforms for sharing regulatory expertise globally – the International Association of Medical Regulators (IAMRA), the Council on Licensure, Enforcement and Regulation (CLEAR) and International Network of Physical Therapy Regulatory Authorities (INPTRA). There are of course other health and care conferences where regulation features. For example, the World Health Organisation (WHO) has held three conferences over the last ten years with a focus on health regulation, with participants from across the globe, including South America, the Indian subcontinent and Africa.

The value of international networks

- Exchange of individual information between countries in the interests of public safety
- Sharing research evidence
- Sharing good practice
- Influencing regulatory policy

The HCPC has been at the forefront of international exchange in regulation for many years. It hosts information on its website www.healthregulation.org, providing information on regulation globally. It has visited different parts of the globe, and written reports on discrete areas of regulation, such as quality assurance and negative licensing, and has hosted its own international conferences in 2013 and 2015. The HCPC has established strong working relationships with its UK regulatory counterparts through its membership of the Alliance of UK Health Regulators on Europe (AURE), particularly on the implementation of the revised recognition of professional qualifications (RPQ) Directive (Directive 2005/36/EC)[1]. It has established a strong network within the EU itself, which has included working with colleagues at the European Commission on the development and implementation of the European Professional Card (EPC). Beyond the EU, it has worked with government officials and regulators from over 16 countries, some of whom are at the start of the process of regulating health professions, others well established and interested in exploring different ways of working. There is an increasing interest in multi-professional regulation across many countries. The HCPC has been working closely with the Australian regulatory body, the Australian Health Practitioner Regulatory Agency (AHPRA) in recent years, with an ongoing programme of exchange of people across different departments. This has proved beneficial for both organisations as it allows for indepth sharing of information and experience. AHPRA is perhaps the closest to the HCPC in its regulatory structure, in that it holds a register of 590,000 professionals across 14 professions, including nursing, physiotherapy, dentistry and medicine. However, unlike the HCPC, each profession has its own board. (www.aphra.org)

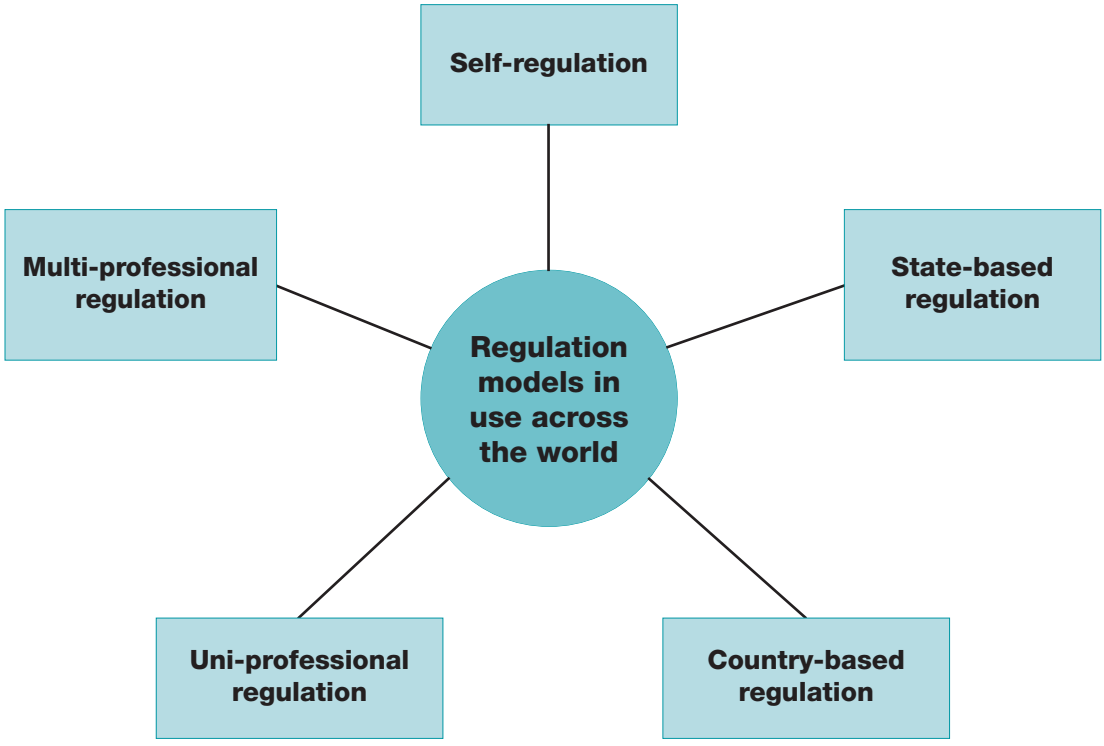
[1] Further information on AURE is available: www.ahpra.gov.au

Examples of countries the HCPC has had visits from, 2002–15

Australia
Botswana
Brunei
Canada
Channel Islands
China
Hong Kong
Isle of Man
Malaysia
The Netherlands
New Zealand
Norway
Republic of Ireland
Singapore
South Africa
Taiwan

There are of course significant challenges in sharing good regulatory practice, and there are inherent dangers in assuming one model is superior to all others; or that one regulatory regime could work well in another culture. No two countries have the same legislative framework, the same history, or the same cultural or economic context. For example in the US, regulation is state based, which means that a health or care professional in Maryland cannot practise outside the state without applying for a state license. Different regulators have very different relationships with those they regulate. In the European Union (EU), for example, many of the 'competent authorities' (regulators in the UK) are also professional associations. In some countries, self-regulation by professional bodies and associations is the norm, in others, regulation is administered by the government. In poorer countries, regulation in health and care is frequently frequently unaffordable.

Figure 3 Regulation models in use across the world



Despite these differences, when regulators come together they find much to discuss. They may approach regulatory functions in a variety of ways, and some have wider legal powers than others, but there are common themes that have emerged in the international debate.

8.1 Lay involvement in regulation

Although there are very different models in operation across the world, there appears to be an increasing appetite for public involvement in regulatory decisions. High profile failures in regulatory decisions, be they in registration or disciplinary decisions, have often been attributed to professionals looking after their own, and showing undue leniency when it comes to decisions about professional colleagues (Thomas, 2007, Brock, 2008). In many countries, this has been one of the strongest political motivators in bringing a 'lay' voice into regulatory environments. The politicians, press and public have all demanded it. There can be little doubt that, by balancing lay and professional involvement on regulatory boards and disciplinary panels, the risk of conflicts of interest interfering in decision making diminishes. Conflicts such as these are often unconscious, unspoken. Jack Cochran, former surgeon, now Executive Director of Kaiser Permenante in the US, spoke at a recent conference about 'dirty little secrets' in American medicine, where it is common knowledge locally that doctors will not refer their family and friends to certain doctors. Patients don't know about this. Other staff become tense. These doctors typically become more and more isolated, and the risks of poor practice increase (Cochran, 2014, Zubin et al, 2015).

Countries are at very different stages in the development of parity between lay and professional involvement, but there is recognition that this model is likely to be in the best interest of the public. In 2012, Elizabeth Davis, keynote speaker at an international conference in Canada, challenged delegates to 'remember on whose behalf regulatory authorities work'. Any endeavor which is about promoting, protecting or maintaining the health of the public must involve the public (Davis, 2012). At the same conference, Ron Paterson proposed that good regulators must be 'watch dogs, not guide dogs' who must bark when they see harm (Paterson, 2012).

Introducing lay involvement can be challenging, especially when the professions have a powerful political voice resisting change or when they form such a small professional group that it becomes difficult to recruit lay people to the work. On the other hand, when lay people do become involved, regulatory decisions are perceived to be, and in all probability are, more credible, and regulatory bodies are more trusted by the public. One of the clear lessons from the experience of those who have introduced public involvement has been this; lay people must be equals around the table, not viewed as tokenistic contributors there to satisfy political imperatives.

8.2 Research evidence

There are many examples of the way in which evidence has had an important influence on policy and practice in professional regulation worldwide. One example is in the area of continuing competence. Regulators around the world have different approaches to assuring the continuing competence of those on their registers. These different approaches are often driven by political as well as professional influences. Canada has been a leader in this area for many decades, and has probably produced more research than any other jurisdiction to date. For example, Andre Jacques and his colleagues in Quebec have been particularly active in looking at trends and generating findings which have relevance elsewhere. They found that the age and place

of qualification of doctors are consistent predictors of continuing competence (Goulet and Jacques, 2005). As a result, the regulatory system in Quebec has taken a risk-based approach, focusing resources on those at highest risk of poor performance rather than auditing all doctors in the same way. Elizabeth Wenghofer and colleagues have also contributed to the evidence base in this area by looking more closely at the impact of continuing professional development activities on performance. (Wenghofer et al, 2014, 2015). Her study of 2,792 doctors found that those who undertook CPD were less likely to have complaints made against them than those who did not. Futhermore, those who undertook group CPD activities were even less likely to find themselves the subject of a complaint.

8.3 Costs of regulation

Cost is an increasingly important theme across regulatory borders. Government, professionals and regulators are seeking to quantify the costs of regulation, and to look more closely at the reasons why costs differ so significantly between countries and professions. The CHRE commissioned a cost effectiveness study in the UK, which outlined some of the huge disparities in the unit costs of regulation across the nine health regulatory bodies of the UK, concluding that, on almost all measures (such as fitness to practise or registration), multi-professional regulation was the most cost effective (Ball and Rose, 2012). The HCPC has published a detailed study of the costs of its fitness to practise processes at each stage, providing valuable comparisons in cost data for other regulators. Of particular interest was the finding that profession itself was not a predictor, rather, the nature of the complaint and the context were the significant determinants of cost (Redding and Nicodemo, 2015).

8.4 Workforce migration

In 2012, Stephanie Short and Fiona McDonald published an important book on health workforce governance (Short and McDonald, 2012), the first collection of papers in a global context. One of the issues explored in the book is workforce migration. There are a number of forces at work – richer countries have supply and demand issues and often seek a new source of supply overseas, poorer countries cannot provide the same pay and conditions and therefore professionals choose not to remain in their country of origin, where health resources are most needed. In 2012, there were 57 priority countries suffering from severe health worker shortages (Iredale 2012). Regulation is charged with ensuring that health and care professionals who train in another country are judged to be fit to practise in their country. In general, the assessments to ensure that this happens and that information exchange between countries takes place in the interest of the public are robust, although this does vary from country to country. Regulation itself has little, if any, influence on economic or social drivers for occupational mobility. There are some who argue that regulation should exert more influence, in order to prevent migration out of countries with fewer health resources. Iredale argues that the single most important change in policy is that receiving countries should become more self-sufficient in training an adequate supply. This would not of course remove the economic drivers that lead to movement of professionals attracted by higher wages in other countries. Migration is not a problem that regulators can solve, nor indeed individual countries, but it is a debate that needs to be given higher priority on a global scale. Regulators can be a vital source of information in this.

8.5 The European Union

If one were to compare health regulatory landscapes on different continents, the European Union (EU) has probably developed a

model for mutual recognition of professional qualifications more successfully than any other. This is because amongst its many aims, the EU seeks to establish a free market, with the free movement of goods, persons and services, and a common trade policy to strengthen its economic position place in the world markets. There are 28 member states, 23 languages, 6,000 regulated professions. 41 per cent of these individuals work in health and social care (Binczyk, 2015). The type and scope of regulation varies enormously from member state to member state. For example, some EU states have no regulation for health and care professions. Others regulate by protection of title, other through reserved activities, or a mixture of the two. Certain health professions (doctors, nurses, midwives, pharmacists, dentists and vets) have the right to have their professional qualifications automatically recognised in any other member state, principally because minimum training requirements for these professions have been harmonised across member states. They are known as the 'sectoral professions' under the Recognition of Professional Qualifications (RPQ) Directive. The remaining health and care professions come under the 'general system', of the RPQ Directive whereby minimum training conditions are not harmonised across member states and recognition is granted on the basis of a comparison of professional qualifications (or regulated education and training) between member states on a case-by-case basis. The RPQ Directive also allows the host country, under the general system, to require an applicant to pass an aptitude test or complete a period of adaptation prior to recognising their qualification. This would be recommended in cases where there are significant shortfalls in the education and training (which has not been compensated elsewhere) from what is required in the host member state for entry to the profession.

In the last five years, the EU has been moving towards strengthening the recognition of professional qualification provisions between member states as governed by the RPQ Directive. A revised Directive was agreed in late 2013, and will be fully operational in 2016. It will include strengthening language requirements where there is any patient safety issue, developing a proactive fitness to practise alert mechanism for regulators to inform their European regulatory counterparts if a professional's practice has been restricted or prohibited (even temporarily); and the introduction of the European Professional Card (EPC) for certain professions such as physiotherapy. (For a full account on this development, see the HCPC's paper for Council, September 2014, as well as www.eubusiness.com/topics/employment/qualifications)

None of this means that the EU is closer than any other group of countries to achieving consistency across its other regulatory functions. In fact, the EU probably has the most diverse system when it comes to disciplinary processes. However, the principle of recognition, and the fact that the EU does allow free movement, has meant that many health and care professionals from the UK are able to work in other parts of Europe, and professionals from those countries can work in the UK. If a visiting health or social work professional wishes to work in the UK on a temporary and occasional basis, they need to make a declaration with the HCPC under a process more commonly known as 'temporary registration'. EEA applicants who wish to work in the UK on a permanent and more stable basis can submit a separate application under the HCPC International – EEA mutual recognition rights route. Health and care professionals trained outside the EU submit a different international registration application if they are seeking registration in the UK. For more information on this, see www.hcpc-uk.org/apply/eeaandswitzerland

9. Conclusions

This report has described the development of the HCPC, a uniquely multi-professional regulator of health and care professions. There are three components that have been fundamental to the success of the organisation – transparency, involvement and trustworthiness. Of course, within and beyond these are the people who worked so hard to make the organisation what it is.

9.1 Transparency

The HCPC has always vigorously upheld the principle that its work should be conducted in public. This applies to all areas – recruitment, Council and Committee meetings, fitness to practise hearings, policy papers and research. There are some exceptions, for example where legal or contractual constraints apply, but these are few in number, and are always clearly explained. Anyone can read the board papers for meetings online. Decisions about sanctions and the reasons why sanctions are imposed, are in the public domain. Complaints about the organisation are discussed at Council meetings. Nothing, or almost nothing, is hidden. Policy decisions are not made behind closed doors.

9.2 Involvement

Authentic involvement of the public and of the professions has been central to all of the HCPC's endeavours. From the start, lay people were involved as members of Council and as Partners making the day-to-day decisions of regulation. Over the years, users of services have become increasingly important in shaping policy, improving standards, approving education and training, and leading research. At the same time, the organisation has sought to engage with the professions through open dialogue. Being hospitable to criticism, actively seeking to resolve disputes, respecting different viewpoints, have been important manifestations of HCPC's working relationship with the professions. This has also been the case in its working relationships with governments, employers, and educators.

9.3 Trustworthiness

In her exploration of trust in public services, Onora O'Neil encourages the pursuit of trustworthiness, not trust itself (O'Neill, 2002, 2015). This is the path that the HCPC has taken over the years (van der Gaag, 2008). It has built credibility slowly, sometimes painfully through its multi-professional approach, and through this engendered a sense of trustworthiness amongst its stakeholders. This does not mean that all stakeholders have this view all of the time, but it does mean that most do, most of the time. If regulation does not seek to promote trustworthiness and transparency, then it is bound to fail.

9.4 The Team

The making of this multi-professional regulator has been a genuinely collegiate and collaborative endeavor. There can be no doubt that Marc Seale, its Chief Executive since 2002, has had a significant impact on the shape and direction of the organisation. Management of growth on this scale takes exceptional leadership skills. His obsessive adherence to clear operational and governance processes and good project management, together with an openness to innovation and change have probably been amongst the hallmarks of his leadership at the HCPC. Without his executive skills and determination, the HCPC would not have grown or thrived in the way that it has done. He has led a very able Executive team, applying a flat management structure, allowing each Director large doses of autonomy. Employees throughout the organisation have always been encouraged to come forward with ideas for more efficient ways of working, and many of the innovations have come from them.

The recruitment of an Executive Management Team who can work in this way has also been critical to the HCPC's success. This applies as

much to the less outward facing executive roles such as IT, Finance, Secretariat and HR as it does to Policy, Communications, Registrations, Education and Fitness to Practise. Several members of this team have been part of the organisation from very early on, others have joined more recently but there is a high degree of mutual respect and trust within the team, and considerable knowledge and experience. It has had all the characteristics of a cohesive Executive team, not afraid to challenge, highly motivated, with shared values.

Members of the Council have also been an important part of the success of the organisation. Some have come and gone quite quickly, bringing a disruptive but nevertheless important element to the work of the Council. Others have come with a professional agenda, and they have been challenged to turn their focus towards the central focus of the HCPC, which is protecting the public. Being hospitable to criticism, revisiting the values regularly, thinking strategically and taking evidence informed decisions, have all been critical. Perhaps most important of all has been to maintain a team who were genuinely 'equals around the table', people not preoccupied by status or heirarchy.

Organizational Health depends on;

- Minimal politics (people within the organisation resist scheming against each other)
- Minimal confusion (people know the values and purpose of the organisation)
- High levels of morale and productivity
- Low employee turnover

Lencioni, (2012)

9.5 Future directions

What are some of the key challenges for professional regulation in the future? They are most likely to be focused on three main areas – costs, accessibility and transparency and complaints handling.

There is a growing interest worldwide in the varying costs of regulation for different professions, and whether these costs can be justified. Annual UK registration fees currently vary from £80 to £800. Governments are likely to ask regulators to account for their costs, and to become more efficient. The HCPC has been a good model in this regard, and needs to continue to hold to the principles of providing high quality value for money services. The fact that research now indicates that profession in itself is not the major determinant of the costs of fitness to practise will no doubt need to be replicated and explored further in other regulatory contexts. (Redding and Nicodemo, 2015).

A second major challenge will be the extent to which regulators make themselves accessible to the public and to their other stakeholders. Much has already been achieved, but more can be done to make regulatory processes free of jargon, responsive and clearly there to meet the needs of the public. These are issues which will very likely shape the future direction of regulation.

The third challenge lies in the ways in which regulators handle complaints. Responding to people's concerns about care more swiftly, being ever more transparent and innovative about performance and process, and undertaking more research will all be critical. There will need to be a greater choice of regulatory tools, such as alternate dispute resolution, applied on the basis of risk to the public, not profession. There is very little evidence from existing fitness to practise data that risk and the regulatory force required to

address it is determined by profession alone. It is context that is most critical. The risk of sexual abuse, for example, is higher amongst those health and care professionals who work alone with patients and service users than amongst those who work in teams. There are of course some professions who perform higher risk interventions than others, but this in itself does not necessarily determine the incidence of human error or harm. Reflection on practise, peer support and strong regular supervision are probably the most significant mitigators of risk but these mechanisms are not well understood and are not evenly distributed throughout the workforce (Zubin, Moore and Walsh, 2015).

There are significant benefits to multi-professional regulation in terms of cost, clarity and focus. My personal view is that the future of professional health and care regulation is multi-professional, fewer uni-professional regulators, more multi-professional ones. It does not make economic or professional sense to have such different systems of professional regulation in the UK. If the future health and care workforce is integrated, team-based, less hierarchy-driven, with patients and service users at the centre, (Berwick, 2009, 2014, Gawande, 2014) then regulation should, eventually, reflect this.

The HCPC has always been proactive in its desire to extend multi-professional, statutory regulation, in order to ensure wider accountability amongst the health and care workforce. We are just at the start of understanding how the concept of risk impacts on different professions, and the evidence is by no means clear. Until more evidence is forthcoming, there will continue to be debate about whether or not professions should, or should not, be regulated and in what way.

9.6 Reflexive culture

There are seemingly unending supplies of management and organisational theories that could explain the components of success in the making of the HCPC. The one most attractive to me comes from the work of Ralph Stacey and his colleagues, who emphasise the importance of a reflexive culture (Stacey, 2002, Mowles, 2015). A new Council member described the HCPC as a 'thoughtful' organisation, with a willingness to reflect and not be fearful of criticism. One of the essential components for me has been that willingness to challenge the status quo and to seek continuous improvement, at Council and Executive level. This can only come about through in-depth conversations and clearly articulated and well executed project work. Project work, like innovation labs, brings people from different departments and disciplines together, allowing for cross department learning and close team-working which nurtures mutual respect. This ties in closely to Lencioni's description of organisational health (pg 51). Of course, it is the kind of work that is never complete, requiring constant questioning, a small sprinkling of paranoia, and a large amount of luck.

9.7 A final quote

It was the late, great Australian cricket commentator Richie Benaud who said that successful cricket takes luck and skill. In characteristic style, he added:
'But let me give you a bit of advice. Don't try it without the skill.'

The HCPC is a tribute to the skills of many people, working together to make health and care safer and more effective for all.

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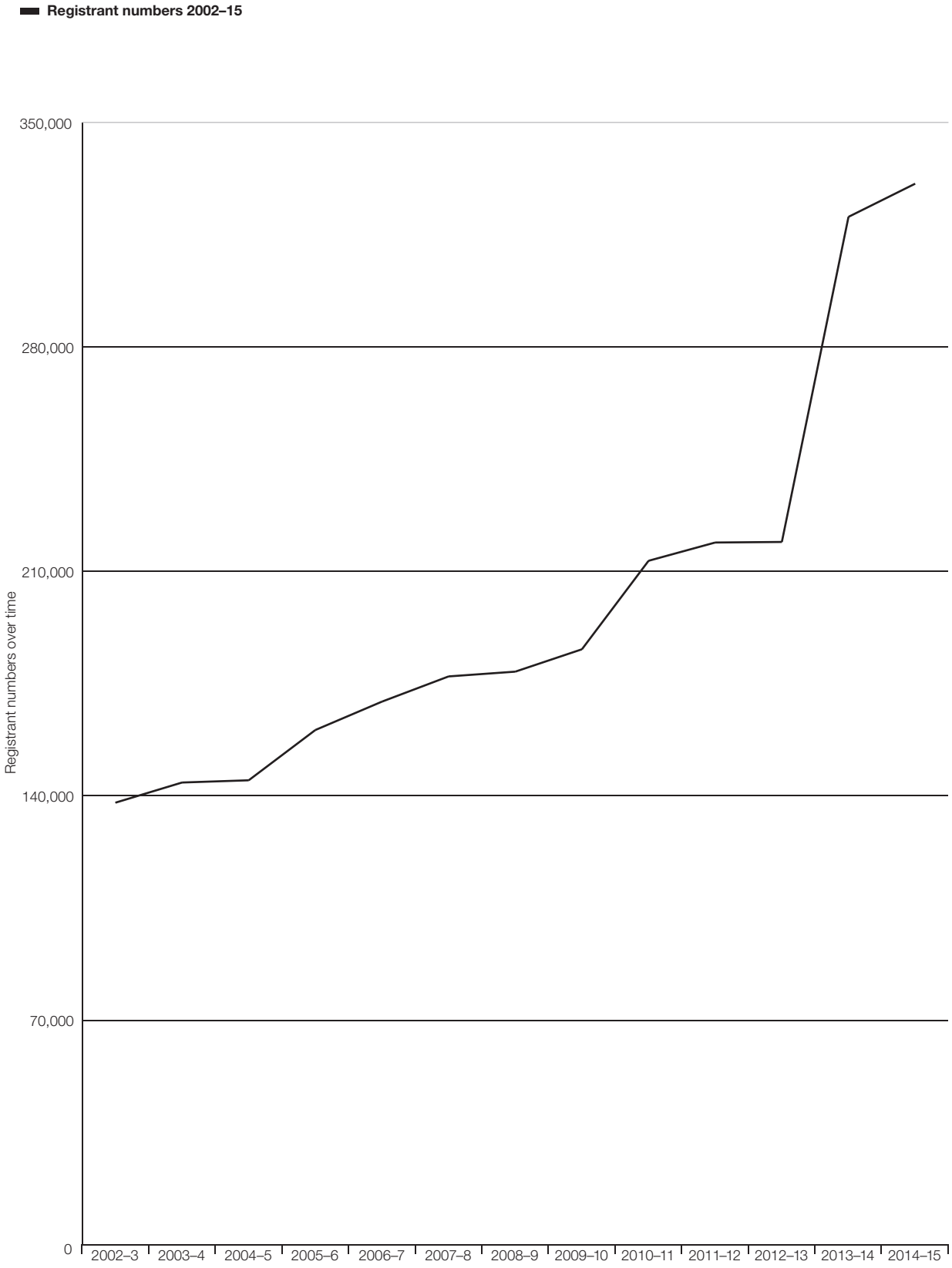
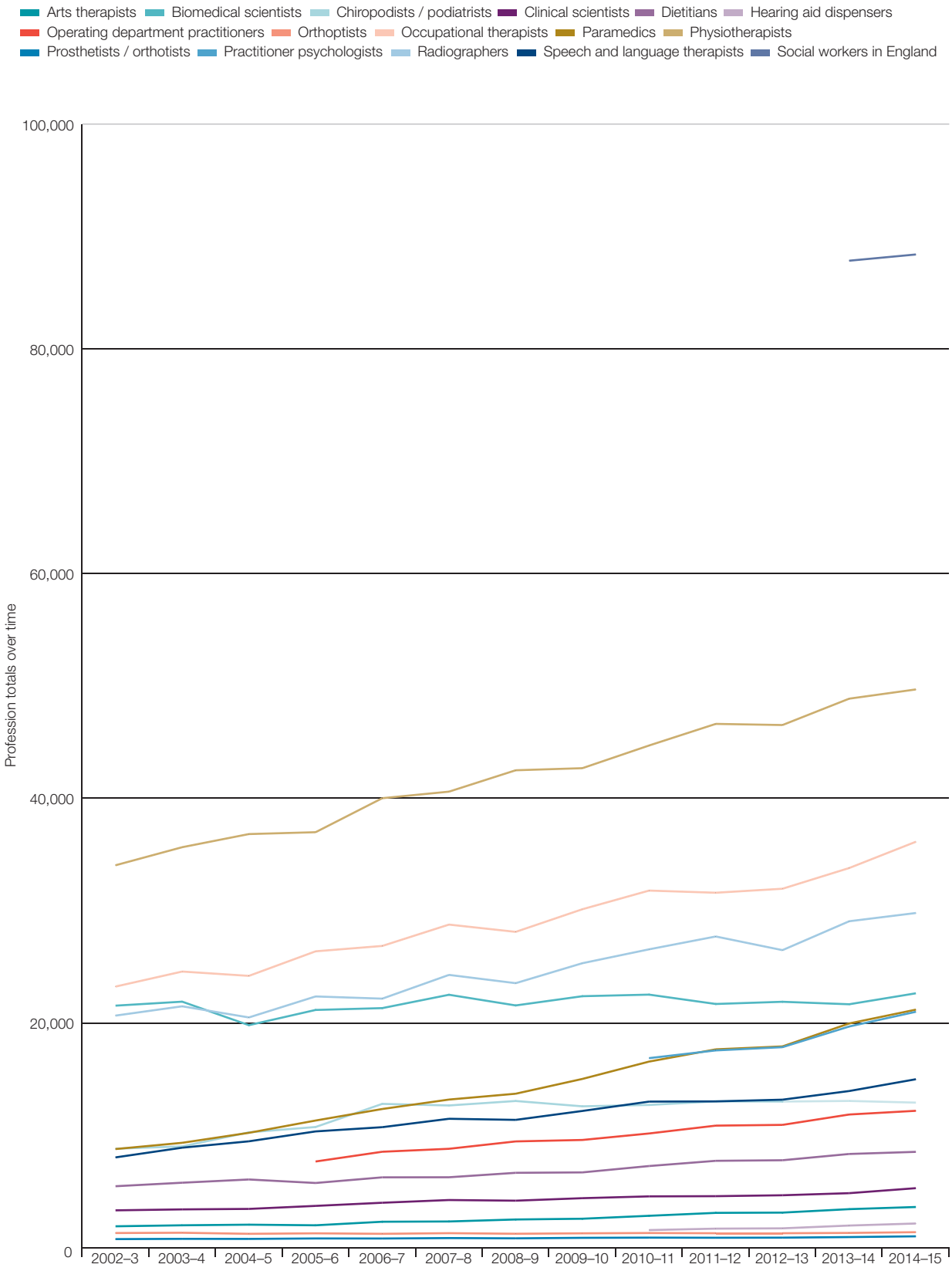
Appendices

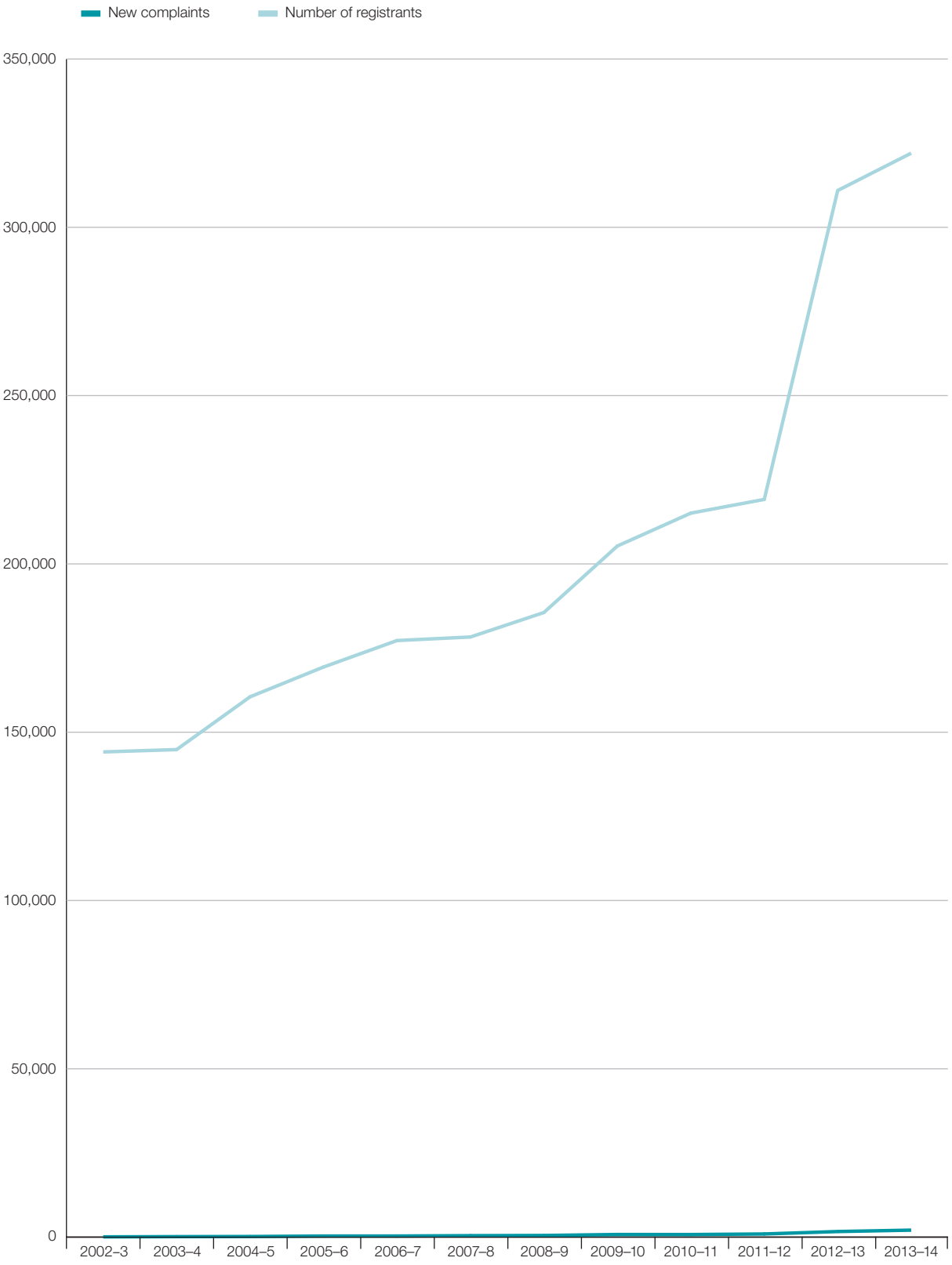
Registrant numbers 2002–15



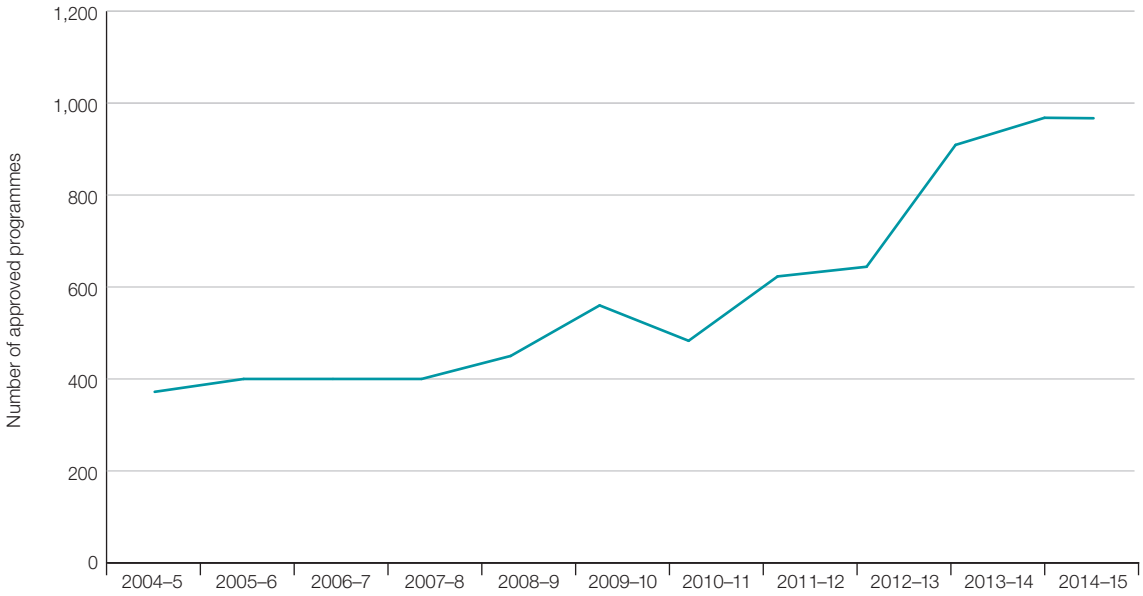
Registrant numbers by Profession 2002–15



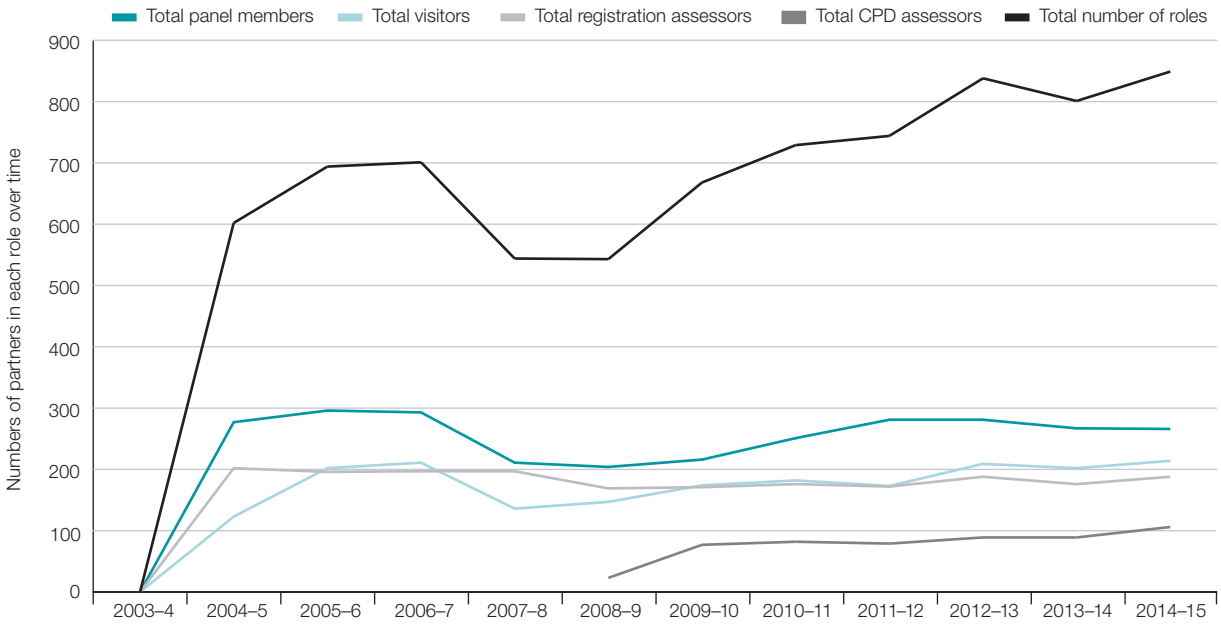
Fitness to practise numbers 2002–14



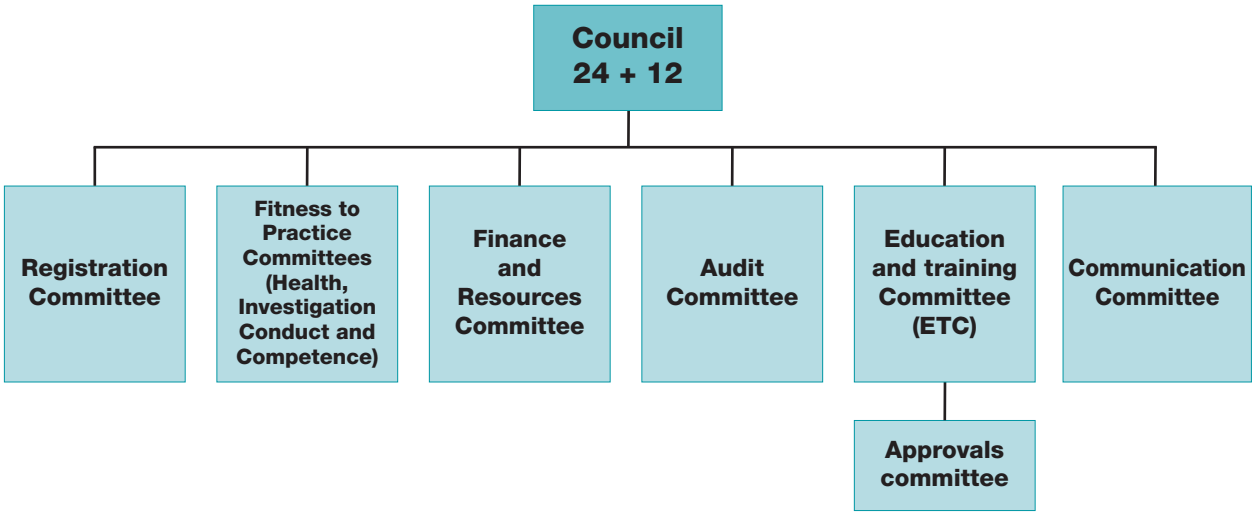
Education approval numbers 2004–15



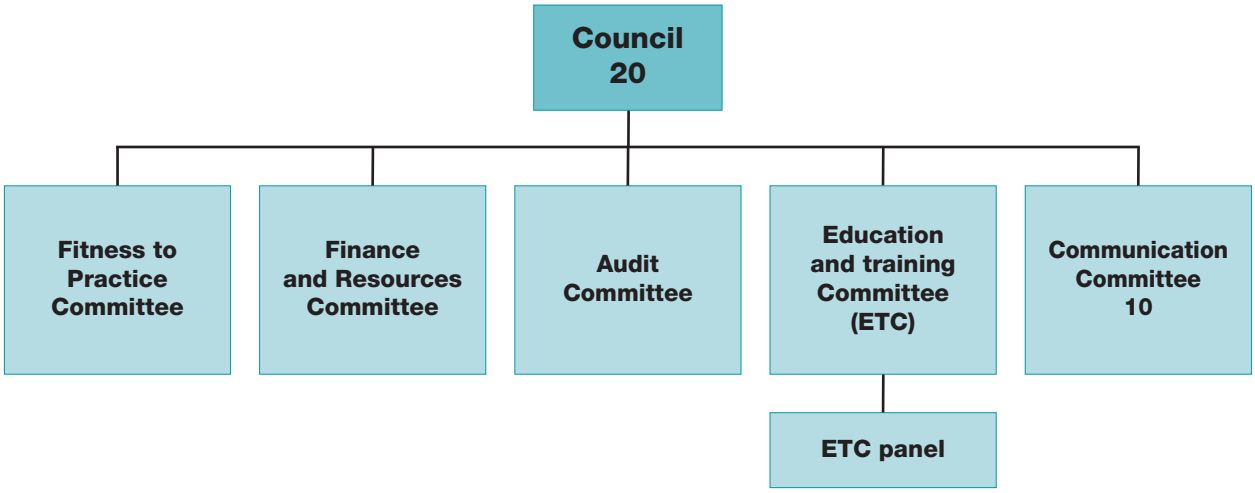
Partner numbers 2003–15



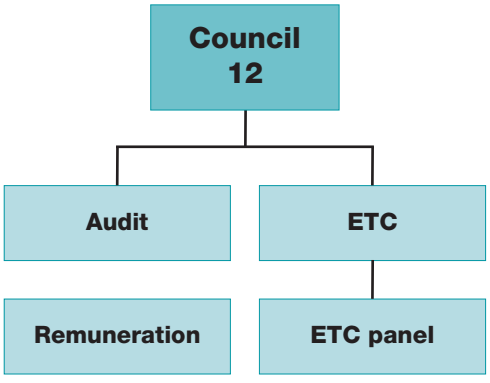
Council structure, including number of members, in 2002



Council structure, including number of members, in 2009



Council structure, including number of members, in 2014



List of abbreviations

AHPRA Australian Health Practitioners Regulation Authority

BPS British Psychological Society

CHRE Council for Healthcare Regulatory Excellence

CLEAR Council on Enforcement, Licensure and Regulation

CPD Continuing Professional Development

CPSM Council for Professions Supplementary to Medicine

CQC Care Quality Commission

GSCC General Social Care Council

HAC Health Aid Council

HCPC Health and Care Professions Council

IAMRA International Association of Medical Regulatory Authorities

NAO National Audit Office

PLG Professional Liaison Group

PSA Professional Standards Authority for health and Social Care

QAA Quality Assurance Agency

SCPE Standards of Conduct Performance and Ethics

SETs Standards of Education and Training

SoPs Standards of Proficiency

SWOG Social Work Oversight Group

List of professions regulated by the HCPC

Arts therapists

Biomedical scientists

Clinical scientists

Chiropodists / podiatrists

Dietitians

Hearing aid dispensers (from 2010)

Occupational therapists

Operating department practitioners (from 2004)

Orthoptists

Paramedics

Physiotherapists

Prosthetists / orthotists

Practitioner psychologists (from 2009)

Radiographers

Social workers in England (from 2012)

Speech and language therapists

Notes

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Published by the Health and Care Professions Council (HCPC)
Publication code: VANDERGAAG15
This document has been produced using trees from sustainable forests

ISBN 978-1-910938-06-5