hcpc health & care professions council

Council, 7 December 2016

Reforming health and care professional regulation

Executive summary and recommendations

Introduction

At the Council meeting on 6 July 2016, the Chief and Executive and Registrar presented on the themes which were to be addressed during the four country 'pre-consultation events' which took place in the summer of 2016. The Executive reported on the content of these events at the Council meeting on 21 September 2016.

We are still expecting a four country government consultation which is planned to inform the content of legislation to reform the legislation of the health and care professional regulators. At the time of writing this paper, no consultation document had yet been published.

The Executive has prepared the attached papers on two of the topics which may feature in the consultation: governance; and joint working and shared services. The purpose of these papers are to outline in more depth the background and issues in each policy area and to invite discussion. The Council's discussion will then inform further conversations and the draft of a response once a consultation has been published.

Decision

This paper is for discussion; no decision is required.

Background information

Presentation given by Marc Seale, Chief Executive and Registrar at the Council meeting on 6 July 2016.
http://www.hcpc-uk.org/assets/documents/100050A9Enc05-Reforminghealthandcareprofessionalregulation.pdf

Council, 21 September 2016. Reforming health and care professional regulation.
http://www.hcpc-uk.org/assets/documents/10005163Enc06-Reforminghealthandcareprofessionalregulation.pdf

Resource implications

None

Financial implications

None

Appendices

- Governance
- Joint working and shared services

Date of paper

24 November 2016

Governance

1. Introduction

1.1 This paper focuses on the following two issues discussed at the pre-consultation events.

- The size of regulatory body councils.
- Unitary boards.

1.2 There may be other issues that we might wish to raise in our response to any forthcoming consultation, depending on its content, such as continuation of the current requirements for membership of councils to be drawn from the four countries of the UK.

2. Background

2.1 All the Councils of the nine statutory regulators of health and care professionals have been progressively reformed, summarised below.

- We consulted in 2004 on proposals for reform, recognising that if we were to regulate further professions, the arrangements in place at that time (requiring at least two new members for each profession) would quickly lead to an unwieldy Council.[1]
- 'Trust, Assurance and Safety' (2007) set out the Government's rationale for reforms (subsequently implemented in 2009). They were driven by a desire to secure public confidence by moving away from electing registrant and alternate members to a competency based appointment process for all Council members and parity of registrant and lay members. Smaller, more 'board like' Councils would ensure focus on strategic matters and oversight of the Executive.[2]
- 'Enabling excellence' (2011) signalled the Government's intention to review the size of Councils to see whether further reforms were required. The Professional Standards Authority (PSA) were commissioned to provide advice on whether smaller Councils would be more effective, which influenced subsequent reforms to reduce Council sizes.[3]

[1] HPC (2004). Consultation on the structure of the register. http://www.hcpc-uk.org/aboutus/consultations/closed/index.asp?id=12
[2] Department of Health (2007). Trust, assurance and safety. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf
[3] Department of Health (2011). Enabling excellence. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf

2.2 The change in the composition of the Health and Care Professions Council over time is summarised in Table 1.

Table 1: The Health and Care Professions Council - 2004 to date

Year	Council composition
2004	40 members (13 lay; 13 registrant; 13 alternate registrant; President)
2009	20 members (10 registrant, 10 lay, inclusive of the Chair)
2012*	12 members (6 registrant, 6 lay, inclusive of the Chair)

*renamed 'Health and Care Professions Council' in 2012

2.3 A summary of existing governance arrangements is included at appendix one.

2.4 The table below shows the composition of the other professional regulators' Councils.

Table 2: Composition of other professional regulators' Councils

Regulator	Council composition
General Chiropractic Council (GCC)	14 members Parity of registrant and lay members
General Dental Council (GDC)	12 members Parity of registrant and lay members
General Medical Council (GMC)	12 members Parity of registrant and lay members
General Optical Council (GOC)	12 members Parity of registrant and lay members
General Osteopathic Council (GOsC)	10 members Parity of registrant and lay members
General Pharmaceutical Council (GPhC)	14 members Parity of registrant and lay members
Nursing and Midwifery Council (NMC)	12 members Parity of registrant and lay members
Pharmaceutical Society of Northern Ireland (PSNI)	14 members Parity of registrant and lay members

3. Board size

3.1 The PSA (then the Council for Healthcare Regulatory Excellence) were commissioned in 2011 by the Department of Health to provide advice on board size.[4] Their report looks at evidence drawn from the public sector, private sector, voluntary sector and from regulatory bodies. The PSA concluded that smaller boards were associated with greater effectiveness, with a range of 8 to 12 members. The PSA suggested that smaller boards may have benefits in communication and speed of decision making, greater inclusiveness and more focus on 'core governance issues' (with less encroachment into matters which should be left to executives). The PSA also noted that a balance needed to be struck between boards having sufficient skills, experience and diversity to be effective and credible whilst avoiding the pitfalls of being too large.

3.2 Other sources reviewed in putting together this paper have generally pre-dated the PSA's paper and have made similar conclusions. Overall, it appears that the evidence for optimum board size is 'mixed and inconclusive'.[5] Some studies have shown a positive correlation between small board size and performance (for example, financial performance) and others that larger boards can still be effective.

3.3 Much of the literature on board effectiveness appears to concern the behaviours required for high performing boards, suggesting that size may be less important than relationships between members (and members and executives) and how this influences the collective decision making process. These behaviours are revisited regularly by the Council and the Executive, particularly during discussion at the annual strategic away day.

4. Unitary boards

4.1 Unitary boards are boards where executives, including the Chief Executive, and non-executives sit together. There is a non-executive majority and a non-executive chair. The Audit Committee and Remuneration Committee (or their equivalent) would include only non-executives.

4.2 This model is frequently used in the private sector and in NHS Trusts and Boards. (NHS Foundation Trusts in England also have a board of governors drawn from public, patient and staff constituencies, with a role to hold the organisation to account.)

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[4] CHRE (2011). Board size and effectiveness: Advice to the Department of Health regarding health professional regulators. http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/board-size-and-effectiveness-2011.pdf?sfvrsn=12

[5] Edwards, M. and Clough, R. (2005). Corporate governance and performance. An exploration of the connection in a public sector context. University of Canberra, Corporate Governance ARC Project. Page 9.

4.3 The tables below look at boards in sector or industry regulators (Table 3) and in professional regulators in other sectors (Table 4). There are no examples we could find of unitary boards amongst other professional regulators.

4.4 Amongst the sector or industry regulators we looked at (Table 3), there are a variety of approaches, with some unitary boards where only the Chief Executive or equivalent is on the Board. In health and care, the Care Quality Commission in England has a unitary board, in contrast to the equivalent bodies in the other countries, where only Healthcare Improvement Scotland has a sole executive (the Chief Executive) on the Board.

Table 3: Comparison of board structures in a selection of industry or sector regulators

Regulator	Unitary board?*	Composition
Care Quality Commission	Yes	13 members (5 executive, 8 non-executive)
Charity Commission	No	6 Non-Executives, including Chair
Financial Conduct Authority	Yes	10 members (2 executive, 8 non-executive)
Ofcom (Communications and media sector)	Yes	9 members (3 executive, 6 non-executive)
Ofqual (Qualifications)	Yes	12 members (1 executive, 11 non-executive) Only the Chief Regulator is on the Board
Ofsted (Education, children's services and skills)	Yes	7 members (1 executive, 6 non-executive) Only HM Chief Inspector is on the Board
Ofwat (Water industry)	Yes	11 members (7 executive, 4 non-executive)

Note - *unitary board defined as one or more executives on the board
- Based on current board compositions

Table 4: Comparison of board structures in a selection of professional regulators in other sectors

Regulator	Unitary board?*	Composition
Architects Registration Board	No	15 members: 7 architects; 8 lay
Bar Standards Board	No	15 members: 6 barristers; 7 lay; 2 non-voting special advisers
Royal College of Veterinary Surgeons	No	42 Council members: 24 veterinary surgeons; 2 members appointed by each university with vet school (9 Vets, 5 lay); 4 appointed by Privy Council (3 lay)
Solicitors Regulation Authority	No	15 members: 7 solicitors; 8 lay

4.5 The Charity Commission's guidance articulates the potential arguments they consider could be made for and against employees sitting on charity boards.[6]

4.6 The potential advantages identified by the Commission include that this might:

- emphasise that the executive and non-executive share responsibility for the direction, control and performance of the charity and owe it the same duty of care;
- reflect the highest standards of modern corporate governance, bringing faster decision making and clearer strategic thinking;
- create a more dynamic mix of expertise and experience ensuring better performance by the trustees in managing the organisation;
- fully engage the executive in the strategic direction of the organisation; and
- promote closer links between other board members and the executive, resulting in stronger governance.

4.7 The possible challenges identified by the Commission include that:

- executive members may be conflicted at certain times, meaning the whole of the board cannot always make joint decisions and might not be able to be held jointly responsible for their actions;

[6] Charity Commission (2014). Operational guidance. F1 and F2. http://ogs.charitycommission.gov.uk/g515a004.aspx

- the disparity of operational knowledge between the executive and non-executive members might negatively impact on governance and decision making;
- the dual role may mean that the executive have undue power and influence over the administration and strategic direction of the charity; and
- having employees on the board might result in lower turnover, resulting in a less diverse and dynamic body of trustees.

4.8 The above appears to reflect well the arguments we found that have been made in other sectors for and against unitary boards. [7] However, some of the challenges outlined above need not arise – for example, conflicts of interest of executives would be minimised by ensuring that decisions about remuneration, for example, are made solely by a committee of non-executive members.

[7] For example, NHS providers has argued for the unitary board model in healthcare.
NHS Providers (2015). 'We need to talk about boards: Boards, leadership and the NHS.'
https://www.nhsproviders.org/media/1057/we-need-to-talk-about-boards-boards-leadership-and-the-nhs.pdf

Appendix 1: Summary of existing governance arrangements

The Council's existing governance arrangements are set out in the Health and Social Work Professions Order 2001 and in the Health and Care Professions Council (Constitution) Order 2009. They are summarised below.

- There are 12 appointed members, with parity between registrant and lay members (6 registrant, 6 lay). The Chair is one of the 12 members.

- At least one member of the Council must live or work wholly or mainly in each of England, Scotland, Wales and Northern Ireland.

- Each member is only permitted to serve up to eight years in any twenty year period.

- Appointments to the Council are made by the Privy Council. The HCPC runs its own appointment process, with oversight from the Professional Standards Authority.

- There are three statutory 'practice committees' that only meet constituted as panels to consider fitness to practise cases: the Conduct and Competence Committee; Health Committee; and Investigating Committee.

- There is only one statutory Committee that performs a policy function: the Education and Training Committee.

- The Audit Committee and Remuneration Committee are non-statutory committees established by the Council.

Joint working and shared services

1.1 The following are areas of 'joint working' between the nine regulators of health and care professionals which were discussed at the pre-consultation events.

- A single organisation hosting a single online register of all registered healthcare professionals.
- A single set of generic standards for all healthcare professionals (underpinned by profession-specific standards owned by the individual regulators).
- A single adjudicator responsible for all fitness to practise decisions.
- A single organisation conducting the HR, finance and/or IT 'back office' functions.

1.2 The content of this paper overlaps to some extent with issues about the most effective configuration of the sector including the number of regulators. This paper does not seek to address those issues directly.

2. Background

2.1 This section differentiates between 'joint working' on policy / standards matters and 'shared services' where services or functions are shared between different organisations.

Joint working

2.2 There has been an increasing expectation over recent years that the regulators of health and care professionals, and the service regulators, work more closely together. The drivers for this have included a desire for more consistency in processes and standards between the nine regulators; documented cases where it has been concluded that regulators failing to work together has contributed to system failures; and joint working as a means to avoid the spectre of more substantial reconfiguration of the sector whilst achieving the same or similar anticipated benefits.

2.3 Routine joint working between the regulators includes attendance at various fora designed to share good practice and intelligence between the professional regulators and with the system regulators; memoranda of understanding between the regulators and other regulators to achieve more consistent sharing of information; and, on occasion, common policy statements between the regulators.

2.4 One example might be candour where the NMC and GMC worked together to produce joint guidance for the first time, a piece of work arising from the recommendations of the Mid Staffordshire Public Inquiry.

Shared services

2.5 'Shared services' refers to the regulators sharing so-called 'back office' functions such as HR and IT and sharing regulatory functions.

2.6 The Professional Standards Authority (PSA; then the Council for Healthcare Regulatory Excellence) was commissioned in the past to provide advice to the Department of Health about the possibility of 'shared functions' between the regulators but concluded that there was no agreement and no conclusions or recommendations that could be made.[1]

2.7 To our knowledge, there are no examples of where the regulators have shared back office functions or regulatory functions.

Law Commissions' review

2.8 In their review of the legislation of the professional regulators, the Law Commissions made a number of recommendations for legislative change in order to better promote co-operation between the professional regulators and between the professional regulators and others. Most of these recommendations were endorsed by the UK Government in its subsequent response, including the following.

- The regulatory bodies should have powers to delegate functions but should retain overall responsibility for those functions.

- There should be a duty for the regulators to co-operate with each other and with other public bodies / authorities such as the police and service regulators. The aim is that this might help overcome lack of clarity around what can be done under existing legislation and therefore to overcome barriers to innovative ways of working.[2]

Regulation rethought

2.9 The PSA's 'Regulation rethought' says in summary the following in this area.

- The regulators should consider opportunities to share functions 'if savings can be realised from doing so'.

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[1] CHRE (2009). Shared functions. http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/shared-functions-2009.pdf?sfvrsn=6

[2] DH (2015). Regulation of healthcare professionals. Regulation of social care professionals in England. The Government's response to Law Commission report 345, Scottish Law Commission report 237 and Northern Ireland Law Commission report 18 (2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399020/Response_Cm_8995.pdf

- The regulators should 'collaborate to establish a shared, public register for statutorily regulated professions'.

- In the context of suggesting the creation of a 'single assurance entity', the PSA argue for common standards (a 'statement of professional practice') with profession or occupation specific standards alongside.

- In the context of suggesting the creation of a 'single assurance entity', the PSA propose a single fitness to practise adjudicator.[3]

Experience of shared services in the public sector

2.10 There are examples of initiatives in the public sector to share services in order to achieve cost efficiencies. Two examples are briefly described below.

2.11 The National Audit Office (NAO) have recently reported on the sharing of back office functions in Central Government through the creation of 'shared services centres' working across government departments.[4]

2.12 The NAO found that whilst the programme had made savings since its creation in 2004, these have yet to exceed investment costs and were considerably less than originally forecast. The NAO pointed to poor leadership and risk management and challenges with implementing new technology. It identified advantages for the Government of the continuing programme but disadvantages to customers (the departments involved) including lack of customisation to their needs.

2.13 Amongst local authorities, 'back office functions' are frequently shared for financial reasons. The Local Government Association (LGA) has reported that at least 337 councils across England are engaged in 416 shared service arrangements, resulting in £462m efficiency savings. It has been reported that savings accrued from sharing services such as HR are relatively small and that the potential for savings is greater from shared procurement. More recently the LGA has suggested that sharing services whilst achieving short term savings may not necessarily lead to significant changes in how those services are delivered.[5]

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[3] PSA (2016). Regulation rethought.
http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=10

[4] National Audit Office (2016). Efficiency and reform in government corporate functions through shared service centres.
https://www.nao.org.uk/report/efficiency-and-reform-in-government-corporate-functions-through-shared-service-centres/

[5] New Local Government Network (2011). Shared necessities: The next generation of shared services
http://www.nlgn.org.uk/public/2011/shared-necessities-the-next-generation-of-shared-services/
House of Commons Library Briefing Paper (2016). Local government: Alternative models of service delivery. http://researchbriefings.files.parliament.uk/documents/SN05950/SN05950.pdf

3. Discussion

Duty of co-operation

3.1 In our response to the consultation on the Law Commissions initial proposals, we agreed with the suggestion of a 'duty to co-operate' and the other legislative proposals in this area. However, we also pointed out that this area was more a matter for policy and practice than it was for legislation. An example of co-operation are the memoranda of understanding we have with a number of organisations, including with the regulators of social workers in Scotland, Wales and Northern Ireland.

3.2 The Health and Social Work Professions Order 2001 already includes a duty to co-operate with other public bodies relevant to our role including the other regulators of social workers in the UK (Article 5(e)). Whilst we already have such a duty, arguably, a consistent duty across the statutory regulators might be helpful (albeit with the caveat that this is unlikely to practically change what we already do).

3.3 Without other legislative changes, a duty to co-operate would not in of itself compel or incentivise greater joint working or shared services between the regulators.

Joint working

3.4 The extent of joint working amongst the regulators of health and care professionals is necessarily constrained because of organisational and legislative boundaries – developing joint guidance, for example, would engage nine different organisations' governance arrangements.

3.5 The suggestion of a single set of generic standards for all healthcare professionals mirrors the HCPC's model with a common core of generic standards of proficiency and generic standards of education and training and standards of conduct, performance and ethics. Such an approach across the regulators in their current configuration may, however, be highly challenging to achieve. Further, it may not fully achieve the desire for more consistent outcomes without greater harmonisation of the processes that use those standards.

Shared services

3.6 A single shared register would not appear feasible unless there was substantial harmonisation of processes between the regulators, otherwise such a register is very likely to be unclear for the public. The reference to an 'organisation' responsible for holding such a register, if delivered within the current configuration of this sector, would increase the number of players involved in the regulation of health and care professionals, not decrease it. This would potentially increase the cost and there may be other practical and logistical challenges to overcome. The PSA does not refer to an 'organisation' and says that this might be a shared portal, but there would nonetheless be challenges with this approach to overcome. Further, the simplest way for a

single register to be held might be to move towards a single regulator or regulatory scheme as suggested by the PSA.

3.7 Evidence from other sectors shows that there are considerable challenges with effectively sharing ‘back office functions’ between organisations and that the cost savings are often not as great as anticipated. The HCPC already shows the cost-efficiencies that can accrue from effectively sharing functions across 16 different professions in a common model (as acknowledged by the PSA). We would argue that the concept of ‘back office’ services is unhelpful as functions such as IT and HR are an integral part of our regulatory model and it would be less effective to deliver them separately. Sharing such services in any event would only attempt to address one of the issues frequently raised with the current configuration of regulators (cost-efficiency); it would not address the desire for greater consistency in standards, processes and decision making and a single point of contact for members of the public.

3.8 A single adjudicator is an attractive proposition but it is worth remembering that a previous attempt at achieving this – the creation of the Office of the Health Professions Adjudicator – failed because of concerns about the initial and ongoing costs. It would also not be without its challenges with respect to ownership and input into the setting of standards which are then adjudicated against by the independent adjudicator. Such an arrangement would only go some way to tackling the challenges around consistency if the sector was not also consolidated at the same time.

3.9 For the reasons above, it is proposed that the most effective way of achieving the benefits anticipated through joint working and shared services might be to reduce the number of regulators.