hcpc health & care professions council

Council, 10 February 2016

Regulation of further professions / occupations

Executive summary and recommendations

Introduction

On 17 December 2015, a ministerial statement by Ben Gummer, Parliamentary Under Secretary of State was published. This indicates the present Government's thinking on professional regulation. The statement is appended to this paper (appendix 1).

In light of the publication of this statement, this attached paper aims to bring together relevant background material about government policy over time, and the HCPC's thinking / approach to date, about the extension of regulation to further professions / occupations.

Decision

This paper is for discussion.

The Council is invited to discuss the HCPC's approach in this area going forward.

Background information

See paper.

In the strategic intent, strategic objective five says: 'To be proactive in influencing the wider regulatory policy agenda'. Underneath that, it says: 'To promote the HCPC's views about the statutory regulation of further professions / occupations, where appropriate.'

http://www.hpc-uk.org/aboutus/aimsandvision/

Resource implications

None

Financial implications

None

Appendices

- Regulation of Health and Social Care Professionals: Written statement – HCWS417.

- Statutory regulation of further professions. Briefing for the UK Parliament Health Committee.

Date of paper

30 January 2016

hcpc health & care professions council

Regulation of further professions / occupations

1. Introduction

1.1 On 17 December 2015, a ministerial statement by Ben Gummer, Parliamentary Under Secretary of State was published. This indicates the present Government's thinking on professional regulation. The statement is appended to this paper (appendix 1).

1.2 In light of the publication of this statement, this attached paper aims to bring together relevant background material about government policy over time, and the HCPC's thinking / approach to date, about the extension of regulation to further professions / occupations.

1.3 The Council is invited to discuss the HCPC's approach in this area going forward.

2. Aspirant groups process[1]

2.1 The Health and Social Work Professions Order 2001 provides the discretionary power for the Council to make recommendations to the Secretary of State and to Scottish Ministers about the regulation of further health professions, and, in England, social care workers. (Articles 3(17) and 3(17A)). The Council also has a discretionary power publish guidance on the criteria to be taken into account in deciding whether a profession / occupation should be regulated.

2.2 In 2003, the Council put in place an 'aspirant groups' or 'new professions' process. Under this process, professional bodies representing professions that aspired to statutory regulation could apply to the Council for a recommendation to be made. They had to demonstrate that they met a set of criteria. The criteria were largely about the group's readiness for regulation – for example, that there was a defined body of knowledge; a voluntary register; and defined routes of entry into the profession.

2.3 Between 2003 and 2011, when the process was closed to new applicants (see section five), the Council made 11 recommendations for the regulation of further professions.

2.4 The recommendations were for the regulation of the following groups.

- Clinical perfusionists (also known as clinical perfusion scientists).
- Clinical physiologists.
- Clinical technologists.

[1] http://www.hcpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/

- Dance movement psychotherapists (also known as dance movement therapists).
- Genetic counsellors.
- Maxillofacial prosthetists and technologists.
- Medical illustrators (clinical photographers).
- Operating department practitioners
- Psychologists (applied)
- Sonographers.
- Sports therapists.

2.5 The Law Commissions', in their review of the professional regulators' legislation, proposed that the HCPC's powers to recommend the regulation of professions should be removed. This was because it considered that any regulator could offer an opinion to Ministers and therefore this power was unnecessary. A power for the PSA was considered, but the Law Commissions concluded that this was also unnecessary.[2]

3. Regulation of further professions

3.1 Since the HCPC Register (then the HPC) formally opened in July 2003, four further professions have become regulated.

3.2 Two of these professions – operating department practitioners (2004) and practitioner psychologists (2009) – were recommended for regulation by the Council. The remaining nine recommendations have not to date resulted in regulation.

3.3 The other two professions were regulated as a result of regulatory reform. Hearing aid dispensers (2010) became HCPC regulated following the abolition of the previous regulator, the Hearing Aid Council. Social workers in England (2012) became HCPC regulated following the abolition of the previous regulator, the General Social Care Council (GSCC).

4. Psychotherapists and counsellors

4.1 In 2007, the Government published the White paper 'Trust, assurance and safety – the regulation of health professionals in the 21st century'.[3]

4.2 This identified three professions as priorities for future regulation: practitioner psychologists (regulated in 2009); psychotherapists and counsellors; and healthcare scientists. They were proposed for regulation because their practice

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[2] The Law Commissions' consultation and subsequent report is available here: http://www.lawcom.gov.uk/project/regulation-of-health-and-social-care-professionals/

[3] Department of Health (2007). Trust, assurance and safety – The regulation of health professionals in the 21st century https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf

was well established and widespread in services and because there was significant risk to patients and public from their practice if poorly done.

4.3 As a result, in 2008 the Council established a Professional Liaison Group (PLG) to assist it in making recommendations about how psychotherapists and counsellors might be regulated. The PLG's recommendations were the subject of a public consultation. In 2011, the new coalition government published its policy on professional regulation – 'Enabling excellence' (see below). The Parliamentary Under Secretary of State subsequently confirmed that it was no longer the Government's intention to regulate this profession.[4]

5. Enabling excellence

5.1 'Enabling excellence' (2011) stated the then coalition government's preference for a system of 'assured voluntary registration' whereby voluntary registers maintained by professional bodies would be accredited by the Professional Standards Authority (PSA) to provide assurance to the public about their operation.[5] The accreditation scheme for voluntary registers has since been introduced and to date 19 registers have become accredited.[6]

5.2 The Council has previously been concerned about the risk of the differences between assured voluntary registration and statutory regulation becoming blurred.[7]

5.3 Enabling excellence also led to changes to legislation which allow the professional regulators to open voluntary registers. This was considered carefully by the Council, which eventually concluded that it did not wish to open any voluntary registers. This was because it considered that statutory regulators holding voluntary registers risked public confusion about the level of protection they should expect. The Council was also concerned about the limitations of voluntary registration stemming from a lack of compulsion to register (i.e. no protection of title) and a lack of enforceable UK wide standards. The Council noted that any voluntary registers would need to be self-financing. To date, none of the professional regulators have opened voluntary registers. The Law Commissions' proposed removing this from legislation in their review. In

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[4] Council, 31 March 2011. Statutory regulation of psychotherapists and counsellors. http://www.hpc-uk.org/assets/documents/10003436Item29-anyotherbusiness.pdf

[5] Department of Health (2011). Enabling excellence – Autonomy and accountability for healthcare professionals, social workers and social care workers. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf

[6] For more information: http://www.professionalstandards.org.uk/accredited-registers

[7] HPC (2012). Health Professions Council response to the Council for Healthcare Regulatory Excellence (CHRE) consultation on 'Accreditation standards for organisations that hold voluntary registers for health and social care occupations'. http://www.hcpc-uk.org/assets/documents/10003FBBHPCresponsetotheCHREconsultationonaccreditedstandardsfororgsthatholdvoluntaryregisters.pdf

response, the Department of Health said that they considered it too early to agree with this conclusion.[8]

5.4 Enabling excellence said that the extension of statutory regulation to currently unregulated professions / occupations would only be considered where there is a ‘compelling case on the basis of public safety risk and where assured voluntary registers are not considered sufficient to manage this risk’ (paragraph 4.12). The Paper was silent, however, on what would constitute such a compelling case and what evidence might indicate that assured voluntary registers were insufficient to manage that risk. (The exception to this policy was herbal medicine practitioners - see section eight).

5.5 The Council took the decision to close the aspirant groups / new professions process to new applications after the publication of ‘Enabling excellence’. This was because it considered that it would not be constructive to continue making recommendations about the regulation of further professions when it was clear that these were highly unlikely to result in the group’s regulation. The completion of an application to the Council was a resource intensive process for the groups involved and one that inevitably raised their expectations about likely future regulation.

6. Regulation of adult social care workers in England

6.1 ‘Enabling excellence’ said that the Department of Health would explore with the HCPC establishing a voluntary register of adult social care workers in England. Social care workers are regulated in different ways in Wales, Scotland and Northern Ireland. However, to date, they have not been regulated in England.

6.2 In November 2012, an HCPC policy statement was published which proposed that, instead of a voluntary register, a suitability scheme should be introduced for adult social care workers in England. Social care workers who were entered into the suitability scheme, following an adjudication process, would be prevented from continuing to work in adult social care in England.[9]

6.3 The UK Parliament Health Committee has subsequently endorsed our proposals, and concluded that in any event voluntary registration of this group would be ineffective.

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[8] Department of Health (2015). The Government’s response to Law Commission report 345, Scottish Law Commission report 237 and Northern Ireland Law Commission report 18 (2014) Cm 8839 SG/2014/26. Paragraph 3.5. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399020/Response_Cm_8995.pdf

[9] HCPC (2012; updated 2014). Proposal for the regulation of adult social care workers in England. http://www.hcpc-uk.org/assets/documents/100049BFHCPCPolicystatement-RegulatingtheadultsocialcareworkforceinEngland(Nov2014).pdf

6.4 The Law Commissions' proposed introducing in primary legislation provision which would allow such schemes to be introduced in the future. This would have needed subsequent secondary legislation, but would have been the first step towards potential implementation of this policy. The Government indicated its support for this recommendation.

7. Health Committee accountability hearing and report

7.1 In January 2014, the Chair and Chief Executive appeared at an accountability hearing convened by the UK Parliament Health Committee. This was the first (and, to date, only) time that the HCPC has been called to appear.

7.2 In its subsequent report, the Committee said, in relation to the professions that we had previously recommended for statutory regulation, that we should identify those professions for which we considered there was a compelling patient safety case for regulation.[10]

7.3 In our response to the Committee's report, we said that we considered that there was a case for the regulation of all of these groups on the basis of patient safety, but acknowledged that that judgement was ultimately for Government, outlining some indicative factors that might be considered in considering the extension of statutory regulation to further groups.[11]

7.4 The Executive subsequently wrote to the professional bodies representing the professions for whom a recommendation had previously been made, asking them for evidence and arguments which would support their case for statutory regulation. This was compiled into a paper, approved by the Council, which was appended to a letter to the Chair of the Health Committee in March 2015. This paper is appended (appendix 2).

7.5 We said in that paper: 'We continue to consider that the professions [previously recommended] should be considered for statutory regulation on the basis of patient safety.' This remains the Executive's line if raised in discussion with stakeholders.

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[10] Health Committee (2014). 2014 Accountability hearing with the Health and Care Professions Council. First report of Session 2014-2015.
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/339/339.pdf

[11] Health Committee (2014). 2014 accountability hearing with the Health and Care Professions Council: Health and Care Professions Council's Response to the Committee's First Report of Session 2014-15
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/731/731.pdf

8. Herbal medicine practitioners

8.1 Enabling excellence said that herbal medicine practitioners (those that use unlicensed herbal medicines as part of their practice) would be brought into regulation. The decision to regulate the group was in part motivated by European medicines legislation which had the effect of no longer permitting herbal medicine practitioners to source unlicensed pre-packaged herbal medicines from third party suppliers. Regulation provided a potential means of allowing this practice to continue and thereby ensuring continued consumer choice.

8.2 Work to regulate this group was halted as a result of a European Court judgement against another member state which raised questions about whether the UK Government's proposed approach would be compliant with EU legislation. The Government subsequently announced that it had asked Professor David Walker, a Deputy Chief Medical Officer, to carry out a review into the regulation of herbal practitioners and herbal products. The Chair's report of that review, published in March 2015, concluded that the profession(s) should not be statutory regulated, in part on the basis of a perceived lack of a robust evidence base of treatment efficacy. The report recommended instead that the relevant professional bodies should be encouraged to apply for accreditation of their registers by the PSA. The Department of Health has yet to formally respond to the report's conclusions and recommendations.[12]

9. Public Health specialists ('non-medical')

9.1 In January 2012, the Government announced that it intended to bring public health specialists from non-medical backgrounds into statutory regulation with the HCPC.[13] This was necessary, it was argued, to close a loophole whereby doctors and dentists who were public health specialists were statutory regulated, but those from non-medical backgrounds were only subject to voluntary registration. In September 2014, the Department of Health consulted on the legislation required to regulate this profession.[14]

[12] Walker, D. (2015). Report on the regulation of herbal medicines and practitioners. http://www.dcscience.net/Report_on_Regulation_of_Herbal_Medicines_and_Practitioners.pdf

[13] Council, 4 July 2013. Regulation of public health specialists. http://www.hcpc-uk.org/assets/documents/100040D5Enc27-Regulationofpublichealthspecialists.pdf

[14] Department of Health (2014). The Health and Care Professions (Public Health Specialists and Miscellaneous Amendments) Order 2015. A consultation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/362507/Public_Health_Specialist_Con_inc_additional_Questions.pdf

9.2 The legislation was not progressed through the Westminster and Scottish parliaments before the 2015 general election. Officials subsequently announced that the regulation of this group was to be reconsidered by ministers in light of overall policy on professional regulation. The ministerial statement says that the Government now considers statutory regulation of this group to be unnecessary, having considered existing arrangements and the principle of proportionality.

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Statutory regulation of further professions

1. Introduction

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

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

1.2 The Health Committee has previously recommended that, in responding to its report of our most recent accountability hearing, the HCPC should list those professions (from those listed in 1.1) for which we considered there was a 'compelling patient safety case for statutory regulation'.[2]

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

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

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

1.4 Information is then provided about each professional group.

1.5 We continue to consider that the professions listed in 1.1 above should be considered for statutory regulation on the basis of patient safety.

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[1] Under Article 3(17) of the Health and Social Work Professions Order 2001 http://www.hcpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/

[2] Health Committee (2014). 2014 Accountability hearing with the Health and Care Professions Council. Paragraph 74.

2. Risks and benefits identified in submissions

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

Risk of harm

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

- There are a broad range of risks of harm associated with the nature of the activities involved in each profession. These interventions included (a combination of) the following.
  - Assessment, interpretation, diagnosis and treatment planning.
  - Invasive procedures.
  - Psychological interventions.
  - Physical interventions.
  - Set-up, maintenance and use of specialist machinery and equipment.

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

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

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

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

Limitations of voluntary registration

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

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

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

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

Barriers caused by lack of statutory regulation

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

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

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

3. Information about individual professions

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

Number of practitioners

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

Profession	Number of registrants
Clinical perfusionists	428
Clinical photographers	Not available at time of submission of this paper
Clinical physiologists	5,943
Clinical technologists	2,980
Dance movement psychotherapists	324
Genetic counsellors	187
Maxillofacial prosthetists	183
Sonographers	800 (approx)
Sports therapists	3,807

N.B: Does not include students or trainees.
Most up to date figures available at time of writing

Clinical perfusionists

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

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

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

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

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

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

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

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

- There are examples of individuals working under the professional title who are not performing any of the duties of this role.

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

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

Clinical photographers

3.6 ‘Medical illustrators’ is a generic term for healthcare scientists who specialise in producing photographs, videos and graphical images for use in healthcare. This includes ‘clinical photographers’.

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

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

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

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

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

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

Clinical physiologists

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

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

3.11 The RCCP has submitted to us information from a survey of its registrants about the incidence of complaints / concerns about the conduct or competence of clinical physiologists. They have also provided case studies of complaints they have dealt with. A summary is provided below.

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

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

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

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

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

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

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

    - A registrant was the subject of a competency assessment owing to concerns about poorly carried out investigations and inadequate reporting. As a result, they were required to undertake remedial

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

Clinical technologists

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

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

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

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

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

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

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

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

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

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

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

Dance movement psychotherapists

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

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

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

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

- Dance movement psychotherapists work in a variety of settings, with individuals and groups including with children and adolsecents, and with patients with learning disabilities, autism, dementia and schizophrenia. They work with very vulnerable patients including, for example, patients with substance misuse problems, patients who self-harm and patients who are at risk of suicide. Statutory regulation would protect these clients and demonstrate the professionalism of dance movement psychotherapists.

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

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

Genetic counsellors

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

3.19 The Association of Genetic Nurses and Counsellors represents genetic counsellors and made the application for statutory regulation to the HCPC in

September 2009. The Genetic Counsellor Registration Board (GCRB) maintains the voluntary register.

3.20 In summary the following arguments have been advanced by the GCRB for statutory regulation.

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

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

- The GCRB has collected data from regional genetic services about the risk incidents that had occurred in their departments. These indicate the risks of genetic counselling practice if poorly performed. They include, for example incidences of misinterpretation of test results leading to inaccurate information being given or patients making decisions they otherwise would not – for example, unnecessary termination of a pregnancy or unnecessary surgery.

- Data from the NHS Litigation Authority from 1995 to 2010 further indicates the risks involved in genetics – for example, there were 31 cases involving alleged errors with genetic information during pregnancy; 22 cases of 'wrongful birth' where a decision to have a child was based on wrong information; and one case where the wrong treatment was given to a leukemia patient following misidentification of a chromosome anomaly.

- There is anecdotal evidence of poor practice by unregistered practitioners. In one reported case, the practitioner was found not to have contacted patients about their genetic test results, with implications for their ongoing healthcare. In another a practitioner had falsified patient records to say that they had provided care to patients when they had not.

- Existing voluntary registration requirements have limitations and are challenging to maintain. A lack of compulsion means that professionals removed from registration owing to concerns about their conduct or competence could remain in practice. There is evidence that employers will sometimes fill vacant posts with individuals who are not registered.

- A voluntary register is costly in terms of professional time and relies heavily on the good will of those involved. There is concern about its long term sustainability.

Maxillofacial prosthetists

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

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

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

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

- In addition to their laboratory practise, maxillofacial prosthetists will work directly on patients in the clinic, operating theatre and in other specialist hospital units (i.e. burns). They will also treat patients in the domiciliary and hospice environments when necessary.

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

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

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

Sonographers

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

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

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

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

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

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

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

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

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

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

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

Sports therapists

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

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

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

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

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

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

- In another case, it was determined that there was inadequate evidence to bring criminal charges, but the evidence nonetheless indicated that an

unregistered individual had formed an inappropriate relationship with a patient and their family and had forged training documents. If statutory regulation had been in place, these matters could be considered as misconduct by the regulator and appropriate action taken.

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

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

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- Cookies
- Email alerts
- RSS feeds
- Contact us

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1.

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- Home
- Parliamentary business
  In this section
  - House of Commons
  - House of Lords
  - What's on
  - Bills & legislation
  - Committees
  - Publications & records
  - Parliament TV
  - News from UK Parliament
  - Topics

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  - Hansard Hansard

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  - Members of the House of Lords
  - Government & Opposition
  - Parliamentary offices
  - Members' allowances
  - Standards and financial interests

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  - Art in Parliament
  - Living Heritage
  - Jobs at Parliament
  - Frequently Asked Questions
  - Watch and Listen
  - Sustainability and environmental performance in Parliament
  - Parliament and Women

  Parliament's role
  -
    Parliamentary Role Models

    Celebrating people who have made Parliament a positive, inclusive working environment

  -

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  - Workplace Equality Networks
  - Civil Service Faststream
- Get involved
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  - Attend an event or request a workshop
  - Submit evidence to a committee inquiry
  - Join a learning programme
  - Watch Parliament at work
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  - Vote in general elections

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  In this section
  - Ways to visit
  - Planning your visit
  - Corporate events and venue hire at The House of Commons
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  - Visit Parliament News
  - Virtual tours

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  - Suffragette themed tours
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  - Teacher training and development
  - Outreach
  - Visit

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- House of Lords
- What's on
- Bills & legislation
- Committees
- Publications & records
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- News
- Topics

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Regulation of Health and Social Care Professionals:Written statement - HCWS417

WS
Department of Health
Made on: 17 December 2015
Made by: Ben Gummer (Parliamentary Under-Secretary of State)
Commons
HCWS417

Regulation of Health and Social Care Professionals

The Government remains committed to reform of the regulation of health and (in England) social care professionals. The Government is grateful for the work of the Law Commissions of England and Wales, Scotland and Northern Ireland in making recommendations and has been considering how best to take these forward.

Our priorities for reform in this area are better regulation, autonomy and cost-effectiveness while maintaining and improving our focus on public protection. We intend to consult on how these priorities can be taken forward, taking account of the Law Commissions' work on simplification and consistency and building on the Professional Standards Authority for Health and Social Care's paper *Rethinking regulation* published in August 2015. We will present proposals that give the regulators the flexibility they need to respond to new challenges in the future without the need for further primary legislation.

We recognise the need for some immediate reform in this area. Subject to Parliamentary time we plan to take forward reforms to regulators' rule-making process and the way that the larger regulators deal with concerns about their registrants. This will improve accountability and make the system more efficient and effective.

This Government remains committed to the principle of proportionate regulation of healthcare professionals. Having considered the arrangements already in place to ensure that Public Health Specialists from backgrounds other than dentistry or medicine are appropriately registered and qualified, the Government does not consider that extending statutory regulation to this professional group is necessary. To this end, it will not be taking forward secondary legislation in this regard.

This statement has also been made in the House of Lords: HLWS421

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