Health Professions Council

4 October 2006

THE REGULATION OF NON-MEDICAL HEALTH PROFESSIONS TOPIC DIVISIONS

Executive Summary and Recommendations

Introduction

To facilitate discussion at the away-day, the various chapters of this consultation document have been divided into the following sections as set out at appendix one. It was felt that the topics of 'revalidation' and 'fitness to practise' were significant enough to merit their own topics, whereas the others have been themed under broad headings.

The President has divided the Council into five groups each with a group facilitator and note taker. Each group will discuss two topics and members are requested to study these sections of the Foster report in depth. Group membership is set out at appendix two.

Decision

This paper is for information only. No decision is required.

Background information

Department of Health Review of Non-Medical Regulation: A Discussion Paper (as discussed at 12 September 2006 Council meeting) is attached to this paper.

All Members are requested to bring their copies of both the Foster and Donaldson reviews to the meeting.

Resource implications

Not applicable

Financial implications

The financial implications of the decisions that arise from this consultation will form part of the HPC's ongoing financial planning.

Appendices

Appendix One – The Regulation of Non-Medical Health Professions: Topic Divisions

Appendix Two – Discussion Groups

Date of paper

22 September 2006

Health Professions Council
12th September 2006

DEPARTMENT OF HEALTH REVIEW OF NON-MEDICAL REGULATION: A DISCUSSION PAPER

Executive Summary and Recommendations

Introduction

On 14th July the Department of Health published its review of non-medical regulation (previously referred to as the '*Foster review*'). This was in the form of a consultation document, with a consultation period that runs until 10th November 2006.

The consultation document contains many important recommendations that could significantly affect the way that the HPC operates, most particularly on the issues of:

- revalidation;
- fitness to practise; and
- post registration qualifications.

The attached document is intended to be a framework to assist the Council in discussing its response to the consultation: drawing out areas that are in accordance with areas of the Council's work, or issues on which the Council has taken a stance, and suggesting questions that arise from the consultation.

Throughout the paper the recommendations from the consultation are quoted in full at the beginning of each 'chapter' in bold type. Potential questions and issues for the Council to discuss are highlighted using bullet points.

The discussions the Council has at its meeting, and the results of the Council's discussion at the away day, will be written up into a full response by the Executive, and sent to the Council for email ratification so that it can be submitted to the Department of Health by the consultation deadline.

Decision

The Council is asked to:

- discuss the attached paper;
- raise any additional points and questions that it feels are missing; and
- agree to use this as the basis for its discussion at the away day.

Background information

The full text of the Department of Health review is available online here:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137239&chk=zkSWnu

A printed copy of the review was distributed to all Council members in August. The Secretariat has a limited number of copies.

Resource implications
Not applicable.

Financial implications
The financial implications of the decisions that arise from this consultation will form part of the HPC's ongoing financial planning.

Background papers
Not applicable.

Appendices
Not applicable.

Date of paper
31st August 2006

Department of Health review of non-medical regulation: a discussion paper

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1. Chapter 2: Streamlining requirements

The consultation document's main recommendations in this area are:

- **Regulators should be more consistent with each other about the standards they require of a person entering the register for the first time, and employers and regulators should agree on common standards as far as possible.**

- **All regulators should adopt a single definition of "good character", one of the legal requirements for getting registration. This should be based on objective tests**

- **When a professional starts their first job they have to get onto a regulator's register and satisfy the requirements of their employer. Employers and regulators should co-ordinate their information requirements so that the person provides each piece of information only once.**

(a) Notes for discussion

(i) Character and objective tests

We support the principle behind the statement that character should be determined by means of objective tests, as this is in accordance with how we currently make a decision regarding the good character of registrants.

- Information gained from organisations may be *objective*, but the decisions that are taken on the basis of this information are necessarily *subjective*: depending on the individual circumstances of the applicant.

(ii) Fitness to practise / fitness for purpose

- There is a distinction between fitness to practise and fit for purpose: in effect, the distinction between the role of the regulator and that of the employer. This distinction is not brought out in the consultation.

- There is an assumption in this chapter that the employer and the regulator are checking the same information with the same purpose.

- In effect, *information* could be shared between employers and regulators, but the decisions made by each should continue to be separately made, and justified if necessary.

(iii) A universal definition of good character

Common standards between professions are at the heart of the HPC's work as a multi-professional regulator. We support the work being undertaken on a universal definition of good character, and look forward to further involvement in the project.

(iv) Arms length decision-making

At HPC, registration decisions are not made by employees, but instead by a panel of partners.

Separation is important for fairness and due process, so decisions can be made by panels (including members of the public and members of the professions) who have been appropriately trained.

It also means that the Executive can support the functions of these panels, and provide information to the Council and Committees who can review their functioning where necessary.

(v) Smart cards / credentialing

There is clear potential for technology to provide ways that information can be shared quickly and securely.

- However, technology can be expensive, and potential projects should be clearly defined and costed at the outset, to ensure that health professionals, through their registration fees, do not end up bearing the cost of mistakes.

- It is also important that those health professionals who do not work for the NHS do not end up subsidising IT solutions which only offer benefits for those who do.

2. Chapter 3: Revalidation

The consultation document's main recommendations in this area are:

- **Revalidation is necessary for all professionals**

- **The regulatory body needs to be in charge of setting the standard which a person must meet to stay on the register.**

- **Information already collected by the employer/commissioner should be used to meet both their and the regulator's needs.**

- **The revalidation system should be both formative (an aid to development) and summative (a check that a required standard is met).**

- **Within the NHS, information gathered under the Knowledge and Skills Framework (KSF) should be the basis of revalidation. Any additional requirements should be justified by risk analysis.**

- **Professionals will fall into one of three groups for revalidation:**
  - **i. employees of an approved body – revalidation carried out as part of the routine staff management or clinical governance system.**
  - **ii. self-employed staff providing services commissioned by NHS primary care organisations – revalidation processes built into the relevant NHS arrangements and carried out under the supervision of the commissioning organisation**
  - **iii. all others – regulatory bodies develop direct revalidation arrangements.**

- **The Healthcare Commission in England (or its equivalent in each of the other UK countries) should approve employers who can deliver reliable revalidation processes.**

- **In addition to information from existing clinical governance systems, further information will be needed for a reliable assessment that a person remains fit to practise. This should however be proportionate and based on risk assessment.**

The HPC supports the notion that health professionals must be fit to practise, and that the public must be assured that the registrants who treat them have continued to maintain their fitness to practise.

(a) Notes for discussion

The Council may wish to consider the following key questions:

- What is the definition of revalidation?
- What risks does revalidation aim to minimise or mitigate?
- What standards should health professionals be assessed against?
- By what means should this assessment be carried out?
- What is the outcome of the revalidation process?

- Who should fund the costs of revalidation?

Can HPC decide how far current appraisal systems could form all or part of revalidation until these questions have been worked through?

(i) What is the definition of revalidation?

- Does there need to be a consistent definition of revalidation across the regulators?

(ii) What risks does revalidation aim to minimise or mitigate?

There are several possible definitions of revalidation. It could be, for example, a system that will:

1. bring to the regulators' attention health professionals who are not fit to practise, and who currently are not the subject of any fitness to practise process (is there evidence to suggest that this is currently an issue?);
2. lower the level at which fitness to practise processes are brought;
3. provide all health professionals with regular, developmental feedback that will encourage them to continue to meet high standards; or
4. 'catch' health professionals early, before an incident has occurred, or before fitness to practise proceedings would normally happen, prevent them from practising and / or provide a means by which they can be supported, trained and bought back into safe and effective practice (is there a link here to the work that the National Clinical Assessment Service does with doctors and dentists? The Council could recommend that in the first instance, the role of the NCAS should be extended to its registrants. This would only cover the statutory sector, but could be an important first step?)

- Results of CPD audits, when available, could provide information which would prove useful in establishing an evidence base for the categories of risk which are suggested in the review.
- Do the risks justify the costs of revalidation?

(iii) What standards should health professionals be assessed against?

- Models of medical revalidation could be said to depend on discrete, well-defined specialisms, strong involvement of established Royal Colleges, and a critical number of doctors engaged in reasonably similar practice to enable effective evaluation and analysis of results.
- Defining specialisms for each profession – how could you then revalidate health professionals in emerging specialisms, or those at the forefront of a new area of the profession, where relevant expertise was only shared between a very small number of other professionals?
- How could or should revalidation work for those health professionals who work in education, management and research, or others in other roles related to their initial training, for example in health policy, or in industry? Council agreed in 2005 a broad definition of 'practising'

(iv) Collecting information on registrants' practice

The suggestion that revalidation should be risk-based accords with the Council's priority of making regulation risk-based and targeted.

- How can regulators consistently and reliably identify those registrants who are working in high risk areas?
- How could we ensure we don't discourage health professionals from moving into these areas?

(v) By what means should this assessment be carried out?

- Refer to current HPC system for international assessment, which costs (according to PKF exercise) £257 per applicant, which is paper-based, and unlikely to suffice for giving robust information about ongoing fitness to practise.
- Any assessment should probably include some practical element and also have a meaningful way of including patient feedback, and feedback from colleagues.

(vi) What is the outcome of the revalidation process?

- The review notably does not mention the anticipated outcome of revalidation. This is an important point that will also inform its definition, and the risks it helps to tackle. Specifically, does revalidation have a 'pass / fail' outcome? And if so, what are the consequences of 'failing'?

- One option is that revalidation leads to an agreed action plan to tackle identified areas where the health professional requires additional input or support. If so, what is the relationship of this process to existing fitness to practise processes?

- Any revalidation proposals may provoke questions from registrants similar to the concerns that were voiced around CPD, where registrants wanted specific information about the 'minimum' that they had to do in order to remain registered.

(vii) Formative and summative assessment

- Is there a conflict between formative and summative assessment? Formative feedback should be delivered in an environment which is 'safe', whereas any link between revalidation and re-registration could mean health professionals do not want to divulge information about themselves or their colleagues.

- A system currently operated in Canada by the College of Physical Therapists of Ontario is their 'Quality Management Program'. This incorporates existing CPD requirements as well as an "on-site" assessment of competence every 5 to 10 years. This system is purely developmental and supportive in nature. Information gathered during the program is explicitly "ring-fenced" and excluded from the college's fitness to practise or disciplinary procedures.

(viii) Engagement and communication

- Revalidation must be sufficiently clear so that members of the public can understand how health professionals are assessed and what this means. (This

links with Dame Janet Smith's views in the Shipman report, where she said that it was important that the public clearly understood not only what revalidation was designed to achieve but also its limitations.)

- How can we engage health professionals on the issue of revalidation? (lack of 'buy-in' was highlighted by Dame Janet Smith specifically as a weakness in the GMC's early proposals for revalidation)

- Engagement with other groups, including employers, professional bodies, and patient groups, would also be important.

(ix) Costs of revalidation

- However revalidation is designed or implemented, it is likely to be extremely expensive, and could directly lead to substantial increases in registration fees, which would be likely to be unpopular with registrants.

- In addition to the operational costs of running any system for revalidation, there would also be the costs of developing standards, communication, and publicity, and set-up costs for establishing the resources to support the process.

(x) A cultural shift?

- There is an ongoing move in regulation, from initial assessment of fitness to practise towards ongoing fitness to practise. This can be seen in issues such as CPD and post-registration qualifications. This is a cultural shift, which may take time.

- There are other steps that regulators can take, and are taking, to support ongoing fitness to practise, which fall short of revalidation. These include publishing guidance, giving advice to registrants who have queries about standards, and linking CPD with re-registration.

(xi) Conclusion

- Has the case been made for revalidation of the health professionals on HPC's register at this time?

The following might be elements that the Council would want to see in place before it could be taken forward:

- Exploration of the risks, benefits, and costs of revalidation
- Revalidation introduced for doctors, and the success of the process, including benefits and costs, reviewed
- Information gathered from our CPD audits indicating possible risk factors
- Analysis of fitness to practise data from across the regulators, indicating further possible risk factors
- Careful engagement and communication with health professionals, explaining the evidence base and the case for revalidation
- A pilot of any system developed, with a full review, and lessons learnt, before more widespread implementation.

3. Chapter 3: Post registration qualifications

In chapter 3 of the consultation document, the last paragraph is a recommendation around marking registers with post-registration qualifications. This has been pulled out and tackled separately since this is an important issue.

The consultation document's main recommendation in this area is:
Post-registration qualifications should be recorded in the register where the specialisation is relevant to patient care and patient safety, can be defined in terms of extra skills acquired, and is at a level substantially beyond basic registration.

(a) Clear criteria

- Should there be clear, published criteria for marking the register? Some post-registration qualifications may be relevant to registration, and others will not and should not be marked.

Such criteria could include:

- A link between the qualification in question, and a particular role or function which cannot be adequately and safely carried out without the qualification
- A danger to the public if the Register is not marked (eg: people who are unqualified are performing the role)
- A need for the public to easily identify suitably qualified health professionals.
- A clear identification of risk and how this risk would be mitigated by the Register being marked
- A benefit in marking the Register which outweighs the restriction imposed by limiting the role only to those people who have completed the qualification.

(b) Identifying the appropriate level

This recommendation is also very NHS-focussed, particularly in the identification of Band 7 as the level at which specialisation should be recorded.

Further research could be needed here, to identify:

- how to identify equivalent levels outside the NHS;
- how many registrants were working at this level or above, and how many below;
- how many of the registrants working above this level had a specific qualification in order to do so, and how much commonality there is in terms of qualifications gained / areas studied; and
- how many registrants working above this level did not take a specific qualification, and instead had gained appropriate skills and knowledge through a combination of experience and a range of CPD activities.

(c) Approving programmes and setting standards

Thus far, the issue of post-registration qualifications has not been limited to 'marking the register'. It also entails setting and consulting on standards, and carrying out programme approval: this area is not mentioned at all in the consultation document.

(d) Restriction of function or title?

- How does marking the register affect who can carry out the role associated with that qualification? (In the case of supplementary prescribing, and local analgesia and prescription only medicine, specific legislation restricts the prescription and administration of certain drugs to only those registrants whose registration is marked appropriately.)

- Without some kind of restriction either of a professional title, or legislation restricting function, does marking the register add to public protection?

4. Chapter 4: Fitness to practise

The consultation document's main recommendations in this area are:

- **There should be a single source of advice to those who want to express concerns about registrants and a single investigation process at local level that would provide a report and evidence that would, where possible, meet the various needs such as resolving a complaint and deciding whether to refer to a regulator.**

- **CHRE should organise the agreement of protocols for local investigation which would ensure that their findings of fact could be relied on by regulators if a case had to go to them for resolution. Their audit role should be extended to include a duty to sample decisions taken by regulators not to proceed to formal investigation of cases referred to them.**

- **Employers should remain ready to refer the most serious cases to the national regulator, that is, every case where investigation might lead to removal from the register.**

- **The task of adjudicating on concerns about impaired fitness to practise should be carried out either (a) by a single separate adjudicator for all the professions; (b) as now for the non- medical professions, or (c) under the control of regulators as now, but by shared panelists working to common standards. Comments are invited on this.**

- **Each panel hearing a case would include lay and professional members, the background of the professional ones chosen with regard to the area in which the person appearing was working.**

(a) Notes for discussion

(i) Complainants

The whole of this chapter of the consultation document is very employer-focussed. Regulators receive complaints from a range of stakeholders and a range of different types of complainant.

(ii) The single source of advice for complainants

- HPC supports the notion of a single source of advice for complainants (referred to by Dame Janet Smith in the fifth Shipman report as a 'single portal'), in order that they can be appropriately routed in order to pursue their complaint.

- How could it be ensured that complaints were not prevented from reaching the regulators because members of the public were disinclined to follow this route, and preferred another?

(iii) Endorsements of our work

The review identifies several pieces of work that our Practice Committees and Fitness to Practise (FTP) team are currently working on around improving the process, and we are pleased to see these highlighted as examples of best practice:

- Witness care;
- Helpline to take complaints; and
- Better information for complainants.

(iv) Initial notification of concern

The consultation document says, '*It might be possible to introduce a threshold of seriousness below which all cases has to be resolved locally'* and, '*Work is already in hand to determine the thresholds at which regulators would accept referral of cases from PCTs.'*

At HPC we encourage employers to contact us at an early stage if they have concerns about a health professional that could affect their fitness to practise.

- The risk in promoting local resolution is that a serious case could be missed. Is this risk outweighed by the benefits of local resolution?

- There is a range of sanctions available to a regulators' fitness to practise panels, not only striking off (which is the sanction most referred to in the consultation document).

(v) Investigations

The consultation document says that, *'there should be a single investigation at local level that would provide a report and evidence for … different purposes'* and *'CHRE should organise the agreement of protocols for local investigation which would ensure that their findings of fact could be relied on by regulators if a case had to go to them for resolution.'*

- This assumes current duplication of effort by employers and regulators, and our experience does not necessarily bear this out.

(vi) CHRE audit of initial investigation

The consultation document says, *'CHRE's responsibilities should be extended to include audit (possibly on a sample basis) of the initial investigation stage'*

- It is not clear from the wording here is at what stage CHRE should become involved, and with what powers? Does this mean, for example, that CHRE should investigate those cases that are received by the regulators and closed before the investigating stage. (Dame Janet Smith's fifth Shipman Enquiry report said that 65% of complaints received by the GMC were 'administratively closed' by a member of staff, without ever going any further through the process.)
- Or is this intended to mean a role for CHRE in reviewing those cases that were deemed to have 'no case to answer' at Investigating stage? This could be a useful addition to their powers. A review of how this functions across the regulators, with conclusions drawn about how decisions can best be weighed up, determined, and justified, could prove helpful. However, what is not clear

is what power would CHRE then have, if they determined that a panel had incorrectly determined that there was no case to answer? Automatic referral to a hearing?

(vii) Adjudication

We keep our fitness to practise panels at arm's length from the organisation by a number of measures. The most important of these is ensuring that Council members do not sit on panels. We also do not direct panels towards a particular sanction. We have also separated the role of the Hearings Officer (who fixes the hearing, arranging panel members, room bookings, etc.) from that of the Case Manager who deals with the lawyers and other aspects of the case.

The consultation document outlines three possibilities for adjudication of fitness to practise hearings. Each is outlined below, with potential benefits and disadvantages.

Option 1: a single adjudicator

Benefits:

- Consistency of decision-making.
- Removes the uncertainty around regulators' potential conflict of interest.
- Increased public recognition of regulation through greater consistency.

Disadvantages:

- Costs of the single adjudicator, and who would meet these. Costs would include not only the costs of adjudicating, but also additional organisational costs: Human Resources, Information Technology, facilities and buildings, Communications, etc.
- How could full-time panel members be recruited for the smaller professions? Professional input into panels is important not only for matters which are particular to that profession, but also in terms of professionals' faith in the process.

Option 2: a separate adjudicator for doctors, while preserving arrangements for other regulators

Benefits:

- Regulators would not lose the work done thus far in establishing systems, recruiting panels, training panel members, etc.
- This could function as a pilot, to test the new arrangements with one professional group, and act as a basis for future decisions on adjudication.

Disadvantages:

- A difficult precedent is set by having arrangements that are dramatically different for doctors to those that exist for other health professionals.

Option 3 : panels drawn from single pool, trained by CHRE

Benefits

- Clear separation of function.
- Referral of unduly lenient decisions could then be done by the regulator: this would be consistent with the regulators' role of acting in the best interests of the public.

Disadvantages

- Panel members would require training across a variety of regulatory systems (unless the necessary rule changes to bring about this approach were accompanied by other rules to further standardise the fitness to practise systems of the regulators.)

- Funding for the additional functions of CHRE: recruitment, training, reviews, etc.

5. Chapter 5: Healthcare support workers

The consultation document's main recommendation in this area is:
A successful outcome to the Scottish pilot of employer-led regulation of support workers could lead to the adoption of a UK-wide employer-led approach to the regulation of this group of workers.

(a) Notes for discussion

- An employer-led approach to this group could help to mitigate the concerns that have been expressed elsewhere that statutory regulation might be too strong an approach for this group.

- Building on the ongoing Scottish project could be a sensible and measured way of building on their work and ensuring we don't 'reinvent the wheel'.

- However, the relationship between the independent body holding the database, and the employers who would in effect populate the database, would need to be clear.

- Because some (although not all) people progress from a support worker role to a professional role, there would need to be good lines of communication between the employer-led solution and the regulators.

- An employer-led solution could only offer protection to patients in the NHS. It is possible that the development of an employer-led solution might provide the basis for a UK-wide statutory solution in the future?

- There is a precedent for the regulation of workers who are not at what might be termed 'professional' level, in terms of the regulation by the General Social Care Council of social care assistants, and the regulation by the General Dental Council of professions complementary to dentistry.

6. Chapter 6: New roles

The consultation document recommends that:

- **The new roles using the working titles of Anaesthesia Practitioner, Emergency Care Practitioner, Endoscopy Practitioner, Medical Care Practitioner and Surgical Care Practitioner need statutory regulation, if healthcare providers agree they are fit for purpose.**

- **Work remains to be done about the exact form this should take: whether they should be regulated as one group with specialisms, or as up to five separate groups.**

- **One or more existing regulators will become the "lead regulator" for new groups. The lead regulator will set the standards applying to everyone registering as a member of the new group. Where someone joins the new group from an existing profession, they can remain registered with their existing regulator**

(a) Notes for discussion

(i) Criteria for regulating new groups

We welcome the review's endorsement of the HPC's criteria for assessing applications by what we term 'aspirant groups'.

- Regulation offers benefits to the public, but also imposes restrictions.

- Regulation in the past has normally been based on the identification of clear professions, normally with a professional identity which extends beyond a particular work-setting or job role.

- A role should be UK-wide before it is regulated, in the interests of public recognition, consistent regulation, and transferability of qualifications and workforce mobility.

(b) Distributed regulation

The issue of distributed regulation raises a number of questions:

- Public recognition and understanding of the system. If a member of the public wished to complain about a health professional, they may have no way of knowing who their regulator was without asking asking either the professional themselves, or their employer, which they may be unwilling to do.

- Consistency in decision-making in fitness to practise processes.

- The consultation says, 'many professionals feel a degree of loyalty to the specific group in which they were first registered'. Professional loyalty is important and should not be disregarded, however, is professional loyalty, a sufficient reason for developing a model of distributed regulation?

7. Chapter 7: role, structure, functions, governance and numbers of regulators

- **All regulators have the same role of protecting the public.**

- **There are substantial areas in which common standards would be desirable – in particular most aspects of conduct. The regulators and CHRE should work to introduce common standards in all those areas where this would benefit patient safety.**

- **Some or all of the elected professional members of Councils should be replaced by appointed professional members.**

- **Comments are invited on the future balance of Councils between professional and lay members, with the possibility of either a professional majority of one, a lay majority of one or no change.**

- **Changes are needed to the membership of CHRE's Council.**

- **Any new profession coming into statutory regulation should be regulated by one of the existing regulatory bodies, most likely the HPC.**

- **The PSNI should remain as an independent body for the time being but with shared functions with the RPSGB. In the longer term, however, the two societies should amalgamate into a single UK body, following the passage of the necessary primary legislation. At the same time any necessary changes can be made to clarify the separation of the RPSGB's regulatory and professional lead functions.**

- **We will keep under review the question of whether harmonisation delivers the appropriate benefits or whether there should be further progress towards fewer regulatory bodies. We will review the position after five years, in 2011.**

(a) Notes for discussion

(i) Sharing functions

HPC regulates thirteen health professions by operating common operational processes, and common standards with profession-specific elements where appropriate. We believe that this provides a strong basis to show that sharing functions could work.

(ii) Regulating and promoting the profession

- Should any requirement for a regulator to 'promote' the profession be removed from the legislation, to clarify the role of regulators in protecting the public, and to further make clear the distinction between a regulator and a professional body?

(iii) Common standards

One of the most important areas where common standards could potentially be agreed is the various standards of conduct, performance and ethics that the regulators publish. (Common principles have already been agreed between the regulators in 2001).

There could be several benefits to a joint approach from the regulators to this work:

- Lack of duplication in establishing and reviewing standards
- Scope for joint work in patient public involvement – for example so that regulators were not duplicating approaches to the same patient and consumer groups on similar issues.
- Scope for joint publicity and communication (ref: the joint regulators' PPI group and the joint publication), and enhanced public profile of the standards.

(iv) The make-up of Councils

The Council has been discussing at length the topic of the possible re-structuring of the Council. The Council has agreed that registrant members should no longer be elected, but should instead be appointed. Council has also agreed that Councils should be small, to aid effective decision-making, and that an appointed Council should elect its President.

- The structure of Councils must ensure partnership working between professionals and members of the public, and must also help to counter the public perception that regulators are, '*dominated by members of the profession they regulate'* (to quote the consultation).

- Should Councils in future be constituted with a lay majority of one, rather than a professional majority? In practice this is likely to not have a huge effect on the working of the Council, but would send a strong public message about the purpose of regulation.

(v) Changes in the make up of CHRE's Council

- While CHRE was establishing itself, it was very helpful to have strong links between each of the nine regulators, and the CHRE, through the President of each regulator sitting on the CHRE's Council. However, now as CHRE's role is established, and its work underway, a change to the make up of CHRE's Council would be welcomed.

8. Chapter 8 Connections with CMO's report Good doctors, safer patients

(a) Notes for discussion

(i) Disclosing soft information

The consultation document recommends that soft information, 'indicating possible rather than clear concerns', should be 'confidential to the regulator, and disclosed only under certain conditions to for example an employer rather than the public.'

- The disclosure of soft information ties into the proposals for an Independent Barring Board, as part of the implementation of the Bichard report.

- It would be important to define what soft information could be disclosed, and particularly on for what purpose and to whom the soft information would be given out.

- How can regulators reliably determine who is an employer? The assumption behind the consultation document appears to be either that employers are NHS Trusts, or that there is a fixed number of organisations who employ health professionals, who can be identified and their identity validated.

- Would assuring ourselves that information was being given out *only* to employers involve, in effect, maintaining a register of all organisations and individuals who employ health professionals? This would involve considerable time and resources.

(ii) Language testing

We would very much welcome any move that would allow us to require evidence of proficiency in English when an EEA applicant applied to us for registration.

(iii) Registration of students

We note with interest the recommendation to register students. This is an issue that our Education and Training committee have recently considered. The Committee considered that the case for the registration of students had not been made because the Council can currently assess applications for registration, and is not compelled to register those who have completed an approved course. The Committee also noted that student registration would involve duplication of effort. The committee also considered that there was not sufficient evidence to show that student registration would be proportionate to the perceived problem.

(iv) NHS addiction service

- The introduction of an addiction service for health professionals is a positive suggestion that could help to rehabilitate health professionals.

- It would be important that this could be accompanied by action from the regulator where appropriate.

- However, not all health professionals work in the NHS.

(v) Civil standard of proof

The review's recommendation that regulators should use the civil standard of proof is sensible and welcomed, and a strong endorsement of our current fitness to practise system.

We find the civil standard of proof to be a useful, fair and proportionate way of admitting evidence, and conducting fitness to practise proceedings.

Appendix One

The regulation of the non-medical health professions: topic divisions

Topic A 'Principles and governance' grouping

Including:
Chapter 1, what does professional regulation mean today?
Chapter 7: role, structure, functions, governance and numbers of regulators.
Chapter 8: connections with CMO's report Good doctors, safer patients.

Topic B 'Becoming registered' grouping

Including:
Chapter 2: streamlining requirements
Chapter 5: healthcare support workers

Topic C 'Development and specialisation' grouping

Including:
Chapter 3 (part): post registration qualifications
Chapter 6: new roles

Topic D

Chapter 3: revalidation

Topic E

Chapter 4: fitness to practise

APPENDIX TWO

Discussion Groups - The Regulation of Non-Medical Health Professions

Topic A – Principles and Governance

Topic B – Becoming Registered

Topic C – Development and Specialisation

Topic D – Revalidation

Topic E – Fitness to Practise

Group 1 –	Eileen Thornton – Group Facilitator Carol Lloyd Jeff Lucas Alan Mount Diane Waller Sue Griffiths Pam Sabine	Topic C & D
Group 2	Tony Hazell – Group Facilitator Mary Clarke- Glass Robert Clegg Paul Acres Shaheen Chaudhry Jacki Pearce Jacqueline Ladds	Topic A & E
Group 3	Morag MacKellar - Group Facilitator Doug Proctor John Camp Sheila Drayton Elizabeth Ellis Daisy Haggerty Mark Woolcock	Topic E & B
Group 4	Keith Ross - Group Facilitator Barbara Stuart Pat McFadden Morgwn Davies Christopher H Green Jackie Sheridon Niamh O'Sullivan	Topic A & C

Group 5	John Harper – Group Facilitator	Topic B & D
	Annie Turner	
	Ozan Altay	
	Simon Taylor	
	Patricia Blackburn	
	Helen Davis	
	Christine Farrell	

Note Takers and Group Members

Topic A: Simon Leicester and Niamh O'Sullivan (Marc Seale also attending)
Topic B: Greg Ross-Sampson
Topic C: Roy Dunn
Topic D: Larissa Foster and Michael Guthrie
Topic E: Kelly Johnson and Jacqueline Ladds

22 September 2006