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Professional regulation in health and social care

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Summary

Professional regulation plays a vital role in setting and enforcing the standards of professional behaviour, competence and ethics underpinning the day-to-day interactions patients and the public have with the NHS and the variety of other health and social care services within the UK.

Professional regulation existed long before the NHS was created in 1948. *The Medical Act 1858* established the General Council of Medical Education and Registration of the United Kingdom following a long campaign to abolish quackery. The council, later renamed as the General Medical Council, was required to appoint a registrar and maintain a list of all those registered to practice, with powers to remove those found guilty of "infamous conduct of any professional respect."[1] The council was also given a role in medical education, including a degree of control over the syllabus for trainee doctors.

The *1902 Midwives Act*[2] and the *Nursing Registration Act 1919*[3] brought nurses and midwives into regulation at the beginning of the 20th Century, with a requirement that those practising these professions register with the Central Midwives Board and the General Nursing Council respectively.

In the UK nine regulators now regulate 32 professions by law. Professional regulation is a statutory system, but independent from government.

The roles, functions and powers of the nine regulators vary, but all of them perform the following functions. They:

- set standards of competence, conduct and ethics which professionals must meet to register and practise.
- check the quality of education and training courses, including practice placements, to ensure trainees develop the knowledge, skills and qualities to practise competently and safely.
- maintain a public register of professionals that anyone can search.
- investigate complaints about registered professionals and make decisions about whether they should be allowed to continue to practise.[4]

1 The Health Foundation, *The Medical Act 1858*, accessed on 12 June 2017
2 The Health Foundation. Policy Navigator, *The Midwives Act received royal assent in 1902,* accessed on 12 June 2017
3 The Health Foundation. Policy Navigator, *The Nurses Registration Act received royal assent in 1919*, accessed on 12 June 2017
4 Professional Standards Authority, *What the regulators do*, accessed on 12 June 2017

Regulators are funded by the fees paid by registrants to join and remain on the register. The table below sets out the annual fees for each of the nine regulators.

Organisation	Regulated professions	Annual fee
General Chiropractic Council (GCC)	Chiropractors	£800
General Dental Council (GDC)	Dentists, orthodontic therapists, dental hygienists, dental technicians and dental nurses	Dentists: £890 Dental care professionals: £116
General Medical Council (GMC)	Doctors	£425
General Optical Council (GOC)	Optometrists and dispensing opticians	£350
General Osteopathic Council (GOsC)	Osteopaths	£610
General Pharmaceutical Council (GPC)	Pharmacists and pharmacy technicians	Pharmacist: £250 Pharmacy technician: £118
Health and Care Professions Council (HCPC)	Arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, social workers in England, speech and language therapists.	£90
Nursing and Midwifery Council (NMC)	Nurses, midwives and health visitors Nursing associates will also be regulated by the NMC, but the fee is yet to be determined.	£120
Pharmaceutical Society of Northern Ireland (PSNI)	Pharmacists in Northern Ireland	£398

The activity of the nine regulators is overseen by the Professional Standards Authority (PSA). The PSA is responsible for overseeing the operation of professional regulation, but is not accountable for the performance of individual regulators. It is able to intervene by

appealing decisions professional regulators make about a professional's fitness to practise and has powers to impose reforms.

Regulators operate to protect the public as well as to promote and improve the education and practice of their respective professions. While this is the case, professional regulation has been criticised in the past for favouring the professional interests of the professions it regulates over the interests of patients and the public. However, over the last decade, changes to the legislation and working practices of professional regulators have helped to ensure the interests of patients and the public are paramount.

Professional regulators play a vital role in setting and maintaining standards of education and training for their respective professions, as well as the competencies aspiring professionals must demonstrate before they can register. Education and training can be very long and complex in some healthcare professions. Before qualifying as a hospital consultant, trainees study for five years as an undergraduate and at least eight years as a postgraduate. Professional regulators have a vital role in ensuring education and training equips future generations of healthcare professionals with the skills and competencies they will need over the course of their careers.

Professional regulators maintain a register of all qualified professionals, these include general registers and also registers for specific specialities. Registers are publicly available to enable members of the public to check if a healthcare professional is registered and whether or not they have any sanctions on their registration.

Maintaining a register is an important way of ensuring people seeking to practise in the UK meet specified criteria. The European Union's *Mutual Recognition of Professional Qualifications Directive (MRPQ)* facilities the free movement of professionals across member states. Whether the UK continues to adhere to this directive is an important issue in the UK's withdrawal from the European Union. The outcome of these negotiations will have a significant impact on the processes regulators can apply to professionals seeking to practise in the UK from countries within the European Economic Area.

A core role of professional regulators is to set and enforce the standards of ethics, conduct and competence expected of registrants. This role underpins the rest of the regulatory system. Promoting professional practice and continued professional development is central to the role of regulation. With the recent introduction of revalidation for nurses, midwives and doctors, regulators now have a stronger influence on professional behaviour throughout a registrant's career. Revalidation has the potential to be an effective means of driving improvements in professional practice and the quality of care, although it is still a relatively new addition to the regulatory landscape.

Professional regulators play an important role in investigating concerns about a professional's fitness to practise. These can include allegations regarding their health, conduct or competence. However, these processes are hampered by legislation that is widely regarded as being out-of-date. The Government has made changes to the legislation of individual regulators, but reform to date has largely been conducted in a piecemeal fashion through the use of delegated legislation.

The Conservative Party signalled its intention to reform the operation of regulation in their 2017 general election manifesto:

> "we will legislate to reform and rationalise the current outdated system of professional regulation of healthcare professions, based on the advice of professional regulators…" [5]

However, the Queen's Speech did not include any reference to legislation in this area, which suggests that primary legislation is not likely to take place in this session of parliament.

This briefing describes the main functions of professional regulators in more detail, along with some of the prominent debates surrounding this area of health policy as well as the case for reform. Regulators vary in their policies, functions and operations so the focus of this briefing is on the largest regulators: the General Medical Council, the Nursing and Midwifery Council, the Health and Care Professionals Council, the General Dental Council and the General Pharmaceutical Council.

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5 The Conservative Party, *Forward, Together Our Plan for a Stronger Britain and a Prosperous Future*, *The Conservative and Unionist Party Manifesto 2017*, May 2017

1. Background

As health and social care continually advances so do the professional roles within it; the number of distinct health and care professions has increased over the years. Across the UK there are 32 professions regulated in law by nine professional regulators, although there are many more on voluntary registers and other professions that remain unregulated. While the roles and functions of professional regulators vary, the PSA highlight the following four things that regulators do, they:

- set standards of competence, conduct and ethics which professionals must meet to register and practise.
- check the quality of education and training courses, including practice placements, to ensure trainees develop the knowledge, skills and qualities to practise competently and safely.
- maintain a public register of professionals that anyone can search.
- investigate complaints about registered professionals and make decisions about whether they should be allowed to continue to practise.[6]

While the work of regulators only occasionally permeates public consciousness, their role in shaping and enforcing the attitudes, behaviours and competencies of the professions they regulate has a critical influence over people's daily interactions with the NHS and the UK's wider health and social care system, both public and private.[7]

The UK system of professional regulation is statutory, but independent from government. As such, professional regulators receive no Government funding so rely on the fees paid by registrants. According to the Health Foundation:

> "There has been a longstanding consensus, enshrined in the Medical Act of 1858 and maintained in professional regulation ever since, that without independence from government, the clarity of focus on professional issues would be put at risk by short-term or political pressures."[8]

A focus on professional interests, or a bias in favour of them, has been a criticism of professional regulators over the years. On 31 January 2000, Harold Shipman, a GP, was convicted for the murder of 15 of his patients. An independent public inquiry later found Shipman responsible for killing at least 215 patients between 1975 and 1998. Dame Janet Smith, chair of the inquiry, produced six reports between 2002 and 2005. Dame Janet Smith, within the inquiry's fifth report, criticised the culture within the General Medical Council at the time, concluding that:

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6 Professional Standards Authority. *What the regulators do*. Accessed on 12 June 2017
7 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016*
8 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016*

> "Having examined the evidence, I have been driven to the conclusion that the GMC has not, in the past, succeeded in its primary purpose of protecting patients. Instead it has, to a very significant degree, acted in the interests of doctors. Of course, I accept that the GMC also has a duty towards doctors; it must be fair in all its dealings with them. But, in the past, the balance has been wrong and, in my view, the imbalance was due to a culture within the GMC, a set of attitudes and an approach that put what was seen as being fair to doctors ahead of protecting patients."[9]

Over the last decade, changes to the legal responsibilities of professional regulators and the introduction of revalidation for doctors, and most recently nurses, have sought to ensure that the interests of patients and the public remain the paramount concern of regulators. For example, the creation of the Council for the Regulation of Healthcare Professionals by the *NHS Reform and Health Care Professions Act 2002*, followed concerns regarding the conduct of regulatory bodies. The preceding white paper, *Modernising regulation in the health professions,* published in August 2001, suggested that in the past:

> "the internal workings of regulatory bodies had not kept pace with broader changes across the NHS and a perception had arisen that sometimes professional self-interest had been placed before the interests of patients."[10]

The council, now the Professional Standards Authority (PSA) after successive name changes, was established to:

- promote the interests of patients and the public in the performance of functions carried out by the regulatory bodies it oversees
- promote best practice in the performance of those functions
- formulate principles relating to good professional self-regulation, and to encourage regulatory bodies to conform to them
- promote co-operation between regulatory bodies and other bodies performing corresponding functions.[11]

The PSA oversees the work of professional regulators and accredits organisations holding voluntary registers for professionals not regulated by law. *Section 5* of *The Health and Social Care (Safety and Quality) Act 2015*, originally a private members' bill tabled by Conservative MP Jeremy Lefroy, gave the Professional Standards Authority, and certain regulators, an overarching objective of public protection, thereby strengthening the duty of regulators to act in the interest of patients and the public.

The statutory system of professional regulation has arisen over centuries and, as such, there is no overarching framework or mechanism for deciding which professions should be regulated and, if so, how. As the Health Foundation point out:

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9 *Fifth report -Safeguarding Patients: Lessons from the Past – Proposals for the Future. CM 6394, 9 December 2004.* The Stationery Office

10 Department of Health, *Modernising Regulation in the Health Professions*, August 2001

11 *The National Health Service Reform and Health Care Professionals Act 2002.*

> "Who is 'in' and who is 'out' of statutory professional regulation is as much an accident of history as a rigorous risk-based assessment. Perfusionists, who operate heart and lung bypass machines during cardiac surgery, are not regulated in statute. Arts therapists, who use art to help people with emotional and behavioural issues, were brought into statutory regulation in 2003." [12]

For most professions, the system of regulation operates UK wide, unlike much of health policy which is devolved. The Calman Commission on Scottish Devolution listed professional regulation as one of the matters that is best dealt with across the UK. The Commission's rationale was that this would provide clarity and assurance to patients that there is a common approach and set of standards UK-wide and facilitate the mobility of professionals across the UK.[13] Social work, however, is one exception. Across the UK social work is regulated by the Health and Care Professions Council, the Care Council for Wales, the Northern Ireland Social Care Council, and the Scottish Social Services Council. Collectively they are known as 'the Four Councils'. The Four Councils have agreed a Memorandum of Understanding setting out a framework for their working relationship with regards to the regulation of social workers and the approval of social work education across the UK.[14]

12 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016*
13 The Commission on Scottish Devolution, *Serving Scotland Better: Scotland and the United Kingdom in the 21st Century final report*, June 2009
14 House of Commons Library, *Social Work Regulation (England)*, CBP07802, 2 December 2016

2. Education and training

The education and training of healthcare professionals varies in terms of the complexity of training and the length of time it takes to qualify. The role of professional regulation in education and training varies in accordance with this. However, commonly regulators perform the following key functions:

- Setting standards of education and training.
- Approving and assuring institutions delivering training, including the programmes they provide and also the practice placements where students develop the skills, competencies and experience they need.

Setting standards encompasses not only standards for the teaching and assessment delivered by institutions, but also the competencies students need to demonstrate before they are eligible to register in their chosen profession. In some cases, regulators have a role in setting the curricula, for example in specialty training for doctors or in post-registration courses for other health professionals.

The General Medical Council (GMC) also sets standards covering the selection of medical students[15] as well as standards students need to abide by during the course of their training.[16] It is the responsibility of medical schools to establish and implement appropriate ways of responding to concerns about a student's fitness to practise.[17]

Reflecting the complexity of medical education, medical students during their degree are not registered with the GMC. However, in the first year of the Foundation Programme, a two-year programme following medical school, doctors are partially registered with the GMC, before moving to full registration in the second year. Doctors are then fully registered during their specialty training.

Setting standards for education and training plays a critical role in shaping the skills, competencies and qualities of the next generation of healthcare professionals. Regulators have an important role in ensuring that standards of education and training equip graduates for the environment they will work in when they graduate, but also over the course of their careers. Healthcare professionals will increasingly need to work in multi-disciplinary teams, support people to self-manage long-term conditions, and provide care in a patients' own homes or outside of hospital settings. The Nursing and Midwifery Council (NMC) have conducted a review of education standards, which has looked at what

15 General Medical Council, *Our role in education and training*, accessed on 12 June 2017
16 General Medical Council. *Education information for UK medical students*, accessed on 12 June 2017
17 General Medical Council. *Medical Students: professionalism and fitness of practise* accessed on 12 June 2017

the public will need from nurses and midwives in 2030 and beyond. These revised standards went out to public consultation in June 2017. [18]

Regulators also play a role in approving academic institutions (e.g. medical schools), and the programmes they provide (e.g. nursing degrees), and quite often maintain a database of approved institutions and programmes. For example, the NMC maintains a database of 1000 approved programmes and 79 approved education institutions. Institutions need to reapply every 6 years or their approval will lapse. The institution must notify the NMC of any changes to its programmes so the regulator can assess whether these meet the required standards.[19]

Regulators quality assure the teaching and assessment of institutions and programmes. The process differs slightly between the different regulators. However, this usually involves an initial self-assessment by the respective academic institution, which is then followed-up by a visit or inspection. Reviews or inspections conducted by professional regulators usually comprise teams made up of people practising the relevant profession as well as lay members.

The level of self-assessment varies between regulators. The NMC requires an annual self-assessment and for the institutions to self-report any concerns. The NMC then selects institutions for its next round of monitoring reviews, based on this self-assessment as well as feedback it has received from other sources (including concerns raised by students, patients or carers).[20] In contrast, the Health and Care Professions Council requires an annual declaration from respective programmes, followed by a more in-depth audit including internal self-assessment and results of reviews by external examiners.[21]

During their studies, students spend a significant proportion of their time in practice settings, where they apply and refine their skills and develop experience. The role of regulators extends to ensuring that these practice placements meet required standards.

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18 Nursing and Midwifery Council. *NMC programme of change for education: overview of education consultation,* 13 June 2017

19 Nursing and Midwifery Council, *Quality assurance of education,* accessed on 12 June 2017

20 Nursing and Midwifery Council, *Quality assurance of education*, accessed on 12 June 2017

21 Health and Care Professions Council, *Annual Monitoring Process,* accessed on 12 June 2017

3. Registration

3.1 Purpose

Registration is more than just holding a professional's name on a register. Practising a regulated profession without registration is illegal and regulators have powers to remove a professional from their register or to suspended or restrict someone's registration if there is evidence their fitness to practise is impaired.

Professional regulators maintain a register of all qualified professionals, these include general registers and also registers for specific specialities. Registers are publicly available to enable members of the public to check if a healthcare professional is registered and whether or not they have any sanctions on their registration. Employers are responsible for ensuring professionals have the relevant registration for the work they are employed to do.

3.2 Protected titles

Some professional titles are protected by law. For example, HCPC regulate 16 professions with 34 protected titles. It is a criminal offence for someone who is not a registered professional to:

- claim they're registered
- use a designated title
- falsely claim they have qualifications in a regulated profession
- describe the services they provide as that of a regulated profession.[22]

The maintenance of a register enables regulators to assure the public that professionals seeking to practise within the UK meet acceptable standards of competence (including language skills) conduct and ethics.

3.3 Registration of overseas professionals, EU regulations and language testing

The process for overseas professionals seeking entry onto a UK register varies depending on whether or not they are from within the European Union (EU) or the European Economic Area (EEA).

Professionals applying to practise in the UK from outside the EU and the EEA undergo a much more stringent and costly process before they are able to register. For example, a nurse or midwife from outside the EU and the EEA is required to take a test of competence in their respective speciality, for example in adult nursing or mental health nursing. This is then followed by an objective structured clinical examination, in which the safe and effective practice of an applicant is assessed through a series of scenarios, reflective of the day-to-day issues they are likely to

[22] Health and Care Professions Council, *Protected titles*, accessed on 12 June 2017

encounter.[23] This process is similar to the Professional and Linguistic Assessment Board Test (PLAB) doctors from outside the EEA are required to take.

In addition to identification checks and other immigration processes, applicants seeking to register as a nurse or midwife are required to take a language test to demonstrate they have a knowledge of English to enable them to communicate effectively. This includes applicants from countries where English is the first and/or native language.[24]

Some regulators have recently been able to apply language controls to professionals from within the EU and EEA. In 2014, the GMC was given the right to apply language tests to EEA doctors if concerns were expressed about their competence.[25] Since 19 January 2016, an EEA-trained nurse or midwife seeking to register in the UK has had to take a language test unless they can demonstrate that their training was taught and tested in English or they have practised for at least two years in a country where English is the first or native language.[26] The *Health Care and Associated Professions (Knowledge of English) Order 2015 (The Knowledge of English Order*), enables the General Pharmaceutical Council to extend language controls to all applicants wishing to register as a pharmacy professional, including applicants from within the UK as well as the EEA.[27]

In oral evidence the Secretary of State for Health told the Health Committee that the UK's withdrawal from the European Union presents an opportunity to improve the assessment of language skills:

> "under EU law we can test only people's basic English, not their clinical English. Things like that do not seem logical and would be a natural priority for reform in a post-Brexit world."[28]

The *Mutual Recognition of Qualifications Directive*, covering the EU and the EEA, facilitates the free movement of professionals, including healthcare professionals, between participating states. As the principle of the directive is to facilitate the free movement of professionals, it is not focused primarily on health. A report by the Health Foundation on workforce policy in England noted the challenges this directive has created for professional regulation in the UK:

> "This general employment (of Mutual Recognition of Qualifications Directive) focus means that some organisations with a particular health focus remain concerned that on issues of clinical equivalence with other training systems and language and communication skills, the directive has insufficient focus on

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23 Nursing and Midwifery Council, *Trained outside EU/EEA: Information for nurses and midwives outside of the EU or EEA.* accessed on 12 June 2017

24 Nursing and Midwifery Council, *Trained outside EU/EEA: Information for nurses and midwives outside of the EU or EEA*, Accessed on 12 June 2017

25 The House of Commons Health Committee, *Brexit and health and social care – people and process,* HC 640 28 April 2017.

26 Nursing and Midwifery Council. *English language requirements – EU/EEA*, 12 June 2017

27 General Pharmaceutical Council, *Guidance on evidence of English language skills: Ensuring pharmacy professionals have the necessary knowledge of English to practise safely in Great Britain*, September 2016

28 The House of Commons Health Committee, *Brexit and health and social care – people and process,* HC 640 28 April 2017

> patient safety issues and prevents UK regulators from checking overseas health professionals robustly."[29]

The GMC in its evidence to the Health Committee's inquiry on Brexit highlighted impact the *Mutual Recognition of Professional Qualifications Directive* has had on the regulation of medical professionals in the UK:

> "Under European law, doctors who are nationals of the EEA (and those who are entitled to count as such) and hold medical qualifications from another country in the EEA are entitled to have their qualifications recognised and to pursue the medical profession in the UK with the same rights as doctors who qualified in the UK. The advantage of the European framework is that those EEA applicants benefiting from automatic recognition can gain speedy entry onto the medical register. The significant disadvantage is that (unlike doctors who graduated outside of the EEA) the GMC cannot test their competence. Instead we must rely on the robustness of the medical education and regulation system in the doctor's home country for that assurance."[30]

In its report on the 28 April 2017, the Health Committee concluded that Brexit provides an opportunity for the UK to negotiate a "more pragmatic approach" to the *Mutual Recognition of Professional Qualifications Directive.*[31]

The GMC recently consulted on the introduction of a new Medical Licensing Assessment designed to provide a "single objective demonstration that doctors entering the UK register through various routes meet a common threshold of safe practice." Essentially, the MLA would introduce common assessment for doctors seeking entry onto the UK register irrespective of whether they trained in the UK or within or outside the EEA. The MLA would effectively replace the PLAB test, which doctors from overseas are currently required to take before they are able to register.[32]

3.4 Voluntary registers and unregulated professions

In addition to overseeing the work of professional regulators, the PSA accredits organisations that register professionals who are not regulated by law. The registers they accredit are voluntary so professionals can practise unregulated without joining the register. For example, many counsellors and psychotherapists are on accredited registers held by different bodies e.g. British Association of Counselling and Psychotherapy. There are also unregulated professions that operate without any form of registration. These include new roles such as physician associates and many professional roles in social care, such as homecare workers.

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29 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016.* http://www.health.org.uk/publication/fit-purpose

30 The House of Commons Health Committee, *Brexit and health and social care – people and process.* HC 640 28 April 2017

31 The House of Commons Health Committee, *Brexit and health and social care – people and process.* HC 640 28 April 2017

32 General Medical Council, *Medical Licensing Assessment*, accessed on 31 July 2017.

Regulation is often be seen as a bureaucratic barrier, but in some cases there is a strong aspiration for regulation from within professions themselves, both as means of promoting a profession's credibility and as a form of status.

The Royal College for Clinical Physiologists recently called for the Government to bring the profession into statutory regulation. In hospitals clinical physiologists perform a range of tasks such as lung function tests, endoscopies, exercise stress tests, internal ultrasounds and pelvic examinations. The college has highlighted 19 cases of patient harm over the last two years as part of its case for the profession to be regulated.[33] The Nuffield Council for Bioethics has also recently highlighted the limitations of regulation of cosmetic procedures. For example there are no controls over who can provide non-surgical procedures.[34]

The absence of regulation can also have a detrimental impact on the uptake of new roles. For example, the Health Committee, in its report on primary care in April 2016, highlighted the absence of professional regulation was a clear disincentive for those considering whether to employ physician associates, due to the liability they faced as employers taking on an unregulated professional.[35] The Committee's view was that it is not acceptable to encourage people to train as physician associates without giving them, or the public, assurance that their practise will be regulated. [36] Jeremy Hunt, Secretary of State for Health, highlighted that the Government intends to consult on whether physician associates should be regulated.[37]

Incidents or allegations of poor and unsafe care can also put pressure on Government to bring professions into the statutory system of regulation. As the Health Foundation observed:

> "Around a quarter of NHS staff are unregulated support workers, the majority of them nursing assistants. There is significant debate about whether such unregulated staff should be brought within a statutory regime."[38]

The challenge of deciding whether or not a profession should be regulated and, if so, how is made more challenging by the absence of an established method upon which to base these decisions. This point was raised by Harry Cayton, Chief Executive of the Professional Standards Authority, in his evidence to the Health Committee in 2016.

> "We would like, as my chairman says, to build the evidence base so that we have some fairly rational means, otherwise you finish up just responding either to campaigns by groups of professionals

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33 *Safety fears over thousands of unregulated NHS staff*, Health Service Journal, 23 August 2017
34 Nuffield Council for Bioethics, *Cosmetic procedures: ethical issues*, June 2017
35 House of Commons Health Committee, *Primary care*, HC 408 21 April 2016
36 House of Commons Health Committee, *Primary care*, HC 408 21 April 2016
37 Department of Health, *NHS Providers annual conference keynote speech*, Accessed on 26 August 2017
38 Health Foundation, *Fit for Purpose: workforce policy in the English NHS*. *March 2016*

> who want to be regulated or campaigns as a result of some harm that has happened."[39]

A recent response to a parliamentary question on plans to regulate physician associates, advance critical care practitioners, surgical care practitioners and other new roles suggests the Government is keen to adopt a risk-based model. Responding on behalf on the Government, Baroness Chisholm of Owlpen, outlined that:

> "The Government is committed to supporting the development of a modern health and care workforce as part of the continuing drive to provide safe, accessible and high quality care for patients and service users.
>
> The extension of statutory regulation to currently unregulated groups will only be considered where there is a solid body of evidence demonstrating a level of risk to the public which cannot be addressed through other means of assurance, including Accredited Voluntary Registers."[40]

[39] House of Commons Health Committee. *Oral evidence: Professional Standards Authority*, HC 301 5 July 2016

[40] PQ HL969 [on regulation of healthcare professionals] 18 July 2017

4. Professional standards

4.1 Setting standards and guidance

Regulators set professional standards of competence, conduct and ethics. These standards underpin the rest of the regulatory regime, from education and training, to registration and ultimately decisions about whether a professional is fit to practise. Regulators in some cases publish documents setting out what patients can expect from a professional.

Core standards covering behaviour, ethics and competence are usually supplemented by professional guidance on issues practitioners are likely to experience during their day-to-day working lives or issues they may encounter in the course of their careers.

Organisation	Regulated professions	Core standards
General Chiropractic Council (GCC)	Chiropractors	*The Code: Standards of conduct, performance and ethics for chiropractors*
General Dental Council (GDC)	Dentists, orthodontic therapists, dental hygienists, dental technicians and dental nurses	*Standards for the dental team*
General Medical Council (GMC)	Doctors	*Good medical practice*
General Optical Council (GOC)	Optometrists and dispensing opticians	*Standards for Practice for Optometrists and Dispensing Opticians*
General Osteopathic Council (GOsC)	Osteopaths	*Osteopathic practice standards*
General Pharmaceutical Council (GPC)	Pharmacists and pharmacy technicians	*Standards for pharmacy professionals*
Health and Care Professions Council (HCPC)	Arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department	*Standards of performance, conduct and ethics* **Note:** this is supplemented by additional standards covering proficiency, continued professional development, prescribing character and health.

	practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, social workers in England, speech and language therapists..	
Nursing and Midwifery Council (NMC)	Nurses, midwives, health visitors and nursing associates	*The Code: Professional standards of practice and behaviour for nurses and midwives*
Pharmaceutical Society of Northern Ireland (PSNI)	Pharmacists in Northern Ireland	*The Code: professionals standards of conduct, ethics and performance for pharmacists in Northern Ireland*

4.2 Revalidation and continuing professional development

As well as setting standards for the professions they regulate, regulators also have an important role in ensuring those on their register remain fit to practise. Advances in treatments, technologies and ways of delivering care, including ethical conduct, mean regulators have an important role in promoting the continuing professional development of registrants.

In some cases, the continuing professional development is prescribed in law. For example, the *General Dental Council (Continuing Professional Development) (Dentists) Rules Order of Council 2008,* stipulates a minimum number of hours of CPD, and verifiable CPD, which dentists need to undertake during a five year period. Verifiable CPD means training and development that the General Dental Council considers to be appropriate and which can be evidenced. Dentists are therefore required to keep documentary evidence of the verifiable CPD they've undertaken. [41]

Together with the Government, the GMC, and more recently the NMC, have introduced systems known as revalidation in order to ensure registrants remain up-to-date in their chosen profession. These processes, consisting of regular appraisals on a registrant's performance, require professionals to demonstrate their continued fitness to practise periodically, usually every 3-5 years.

[41] General Dental Council, *Continuing Professional Development: for dental professionals*, 30 September 2013.

Since revalidation was introduced in 2012, all doctors must revalidate every 5 years in order to renew their license. Regular appraisals centred on the GMC's *Good medical practice* standards are an integral part of revalidation. To revalidate doctors must demonstrate they have collected, and more importantly reflected on, evidence in their appraisals covering:

- continuing professional development
- quality improvement activity
- significant events
- feedback from colleagues and patients
- complaints and compliments

For doctors, revalidation covers the whole of their medical practice, such as work done across one or more organisations. As part of the revalidation process, a designated body (e.g. an employer) is responsible for providing a doctor with a regular appraisal and support with revalidation. Acting on behalf of the designated body, a responsible officer makes a recommendation to the GMC about whether or not a doctor should be revalidated. Responsible officers have a duty to ensure there are robust systems and clinical governance in place to support revalidation and for making sure that doctors with restrictions on their practise are safely managed. [42]

The revalidation process for nurses and midwives is similar to that of doctors, although with some notable differences. The NMC's revalidation process involves a confirmer rather than a responsible officer. The confirmer is another NMC registrant, preferably a line manager, who checks that the registrant has met the NMC's revalidation requirements. Nurses and midwives must revalidate every 3 years as opposed to every 5 years for doctors. The NMC's requirements for revalidation are quite prescriptive about the number of practice hours and the amount of continuing professional development a nurse or midwife must do to revalidate. The NMC's criteria includes:

- a minimum number of practice hours (the standard is 450 for a nurse or midwife)
- 35 hours of CPD in the 3 years since the last revalidation or since they joined the register
- 5 pieces of practice-related feedback
- 5 written reflective accounts
- a reflective discussion with another NMC registrant
- declaration of professional indemnity.[43]

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42 General Medical Council. *How revalidation works?*, accessed on 12 June 2017.

43 Nursing and Midwifery Council. *How to revalidate with the NMC: requirements for renewing your registration.* accessed on 12 June 2017

Arguments in favour of revalidation have been proposed since the mid-1970s. Despite this, revalidation is a relatively new addition to the conduct of professional regulation. According to the Health Foundation:

> "With the introduction of revalidation for doctors and nurses and the development of similar schemes for the other professions, the professional regulators are increasingly asserting a more present, proactive and career-long influence on their registrants. It is early days, and the systems are still clunky, but revalidation may become a valuable mechanism for improving the quality of practice of the existing 'stock' of health professionals, primarily by strengthening local clinical governance and ensuring more systematic and meaningful appraisal."[44]

Four years since the introduction of revalidation, the vast majority of qualified doctors have now been through the process. Sir Keith Pearson, independent chair of the Revalidation Advisory Board since 2009, recently completed a review of revalidation intended to take stock of the progress so far.

Revalidation, according to Sir Keith Pearson, has delivered notable benefits. For example, his report found evidence that revalidation has strengthened clinical governance within healthcare organisations, helping to identifying doctors in need of improvement and supporting them to do so. However, he made a series of recommendations aimed at improving revalidation for the benefit of patients and doctors, such as: promoting revalidation to patients and improving ways to capture their feedback, providing clarity to doctors about the evidence they need to revalidate and developing systems to support doctors to reflect on the feedback they receive.

While generally positive, the report also acknowledged that the revalidation process for doctors such as locums, who move between services, and those who work outside of mainstream clinical practice, needs to be strengthened.[45]

In July 2017, the GMC published an action plan setting out how it will work with other bodies to implement the recommendations in Sir Keith Pearson's report. The action plan identifies six priorities, these are:

- Making revalidation more accessible to patients and the public
- Reducing burdens and improving the appraisal experience for doctors
- Strengthening assurance where doctors work in multiple locations
- Reducing the number of doctors without a connection
- Tracking the impact of revalidation
- Supporting improved local governance.[46]

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44 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016.*

45 General Medical Council, *Taking revalidation forward, improving the process of relicensing for doctors: Sir Keith Pearson's review of medical revalidation*, January 2017

46 General Medical Council, *Taking revalidation forward: action plan*, July 2017

5. Investigating concerns and taking action

Anyone can make a referral to a professional regulator. However, it is important to remember that the purpose of the regulator is to ensure a professional remains fit to practise. As such, there are limits to their powers and the sanctions they can impose on registrants who have failed to adhere to professional standards. Regulators have a duty to investigate concerns that have been raised with them. These may include issues where a professional's conduct, competence (e.g. performance) or health calls into question their fitness to practise.

Most regulators adopt an initial screening process to assess whether allegations or referrals fall under their responsibility. This may include a judgement about whether an allegation concerns a registered professional's ongoing fitness to practise and if it is possible to find sufficient evidence to judge whether someone's fitness to practise has been breached or impaired.

Quite often regulators contact the professional's employer to see whether they have any concerns covering the person's fitness to practise. Professionals are notified of allegations against them and are given the opportunity to comment.

In addition to this, regulators investigate concerns by collecting evidence, including witness statements and reports from experts. Where concerns are made on health grounds, a regulator may request a report from a professional's GP with their consent or may ask them to undergo a medical test or examination.

During the investigation process most regulators have the ability to apply for interim orders to restrict the practise of a professional under investigation, while the investigation is ongoing.

The NMC and the GMC operate a process whereby a case examiner decides whether there is a case to answer. Two case examiners, one professional and one lay examiner, review each case and must agree a decision.

Where the investigations process identifies that there is a case to answer and no other forms of action are appropriate then they can make a referral to adjudication panels or committees. In some cases, the investigative and adjudication functions of professional regulators are split. For example, the GMC refers cases to the Medical Practitioners Tribunals Service (MPTS), an independent body hosted by the GMC. Similarly, the HCPC has recently established a Health and Care Professions Tribunal Service. Despite being within the HCPC, there is a strong emphasis on the separation between the investigative and adjudicative functions. The NMC in contrast, operate a committee that reviews cases submitted by a case examiner. Until recently, there the NMC had two separate committees, one covering concerns about a nurse or midwife's competence and conduct and another for concerns

about a registrant's health. These have now been streamlined into a single Fitness to Practise Committee.

Hearings can be conducted in public and committee or panels have powers to apply a range of sanctions. Typically, these include:

- suspending a professional's registration
- restricting or placing condition on a professional practice
- issuing a caution
- removing the professional's registration, thus making it illegal for them to practise.

Professionals can appeal a decision at a hearing to the High Court of Justice, the High Court of Justice in Northern Ireland or the Court of Session in Scotland. Conversely, as part of its role in overseeing professional regulators, the Professional Standards Authority, under Section 29 of the National Health Service Reforms and Healthcare Professions Act 2002, reviews all fitness to practise decisions and can refer them to court when they believe the decision is not sufficient to protect the public. The separation of the investigation and adjudication of fitness to practise cases involving doctors, following the creation of the Independent Medical Practitioners Tribunal Service, means that the GMC can also appeal on the basis that the decisions do not adequately protect the public.

6. Case for reform

Most of the nine professional regulators have experienced a rapid growth in the number of referrals made to their fitness to practise functions over the last decade. The rise in referrals is not solely explained by any one factor. Rather is it seen to stem from a mix of influences including less tolerance of poor care by members of the public, professionals and employers and more willingness to report such incidents and a confidence that action will be taken.

For many regulators fitness to practise accounts for a substantial amount of their operating costs, which in turn drive up the fees they charge to registrants. However, existing fitness to practise processes are considered to be inefficient, stressful and overly burdensome as a result of legislative requirements. The Health Foundation note that:

> "This increase in referrals, combined with political and trade union pressure not to increase professional fees, has contributed to growing pressure for further reforms to the regulators to improve the speed and efficiency of their work."[47]

The legislation underpinning fitness to practise has prevented regulators from making efficiencies. While there have been changes to legislation governing fitness to practise and other functions performed by professional regulators, this has been largely piecemeal and has not addressed the need for wider reform. [48]

Even though the GMC has more sanctions at the investigation stage, legislation is still restricting the regulators ability to improve efficiency, as Lord Turnberg, in a debate about professional regulation in February 2017, notes:

> "of the 9,000 complaints a year it has to examine in its fitness to practise committees, a very high proportion could, and should, be dealt with locally by the responsible officer in each trust. But the GMC has to examine every case that meets its criteria. Since the cost of doing so consumes about 60% of the GMC's total budget, it is an enormous waste of money, to say nothing of the trauma to doctors who could easily have been returned to good, safe practice by strong local action."[49]

The Government in February 2011 asked the Law Commission, along with the Scottish Law Commission and the Northern Ireland Law Commission, to conduct a review into how the existing legislative framework covering the regulation of healthcare professionals could be simplified and to publish a draft bill for consultation.[50] The Law Commission published its report and a draft bill in April 2014. The report recommended that healthcare professions should be regulated

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47 Health Foundation, *Fit for Purpose: workforce policy in the English NHS. March 2016.*

48 Regulation of Health and Social Care Professions Etc. Bill [HL] 24 of 2016-17

49 Regulation of Health and Social Care Professions Etc. Bill [HL] 24 of 2016-17

50 Department of Health, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers.* February 2011.

under a single piece of legislation along with a number of other recommendations including:

- an overarching objectives for all regulators.
- the introduction board-like governance.
- a requirement for each regulator to maintain a register and appoint a registrar, along with powers for Government to add, remove or alter parts of a register and introduce new systems of revalidation.
- consistent grounds on which to judge a professional's fitness to practise.
- greater flexibility over how regulators investigate allegations and a test for all referrals based on whether there is a realistic prospect of finding an impairment.
- an expanded range of powers/ interventions at the investigation stage, such as advice or warnings.

The case for reform extends beyond fitness to practise and outdated legislation. The PSA, responsible for overseeing the work of the professional regulators, has called for rethink of the role of regulation. The main arguments put forward by the PSA are set out in Table 3 below. However, the main point underlying these proposals was summed up by the PSA's chief executive, Harry Cayton, in his evidence to the Health Committee in July 2016.

> "we have a regulatory system designed in the 19th century, implemented in the 20th century and no longer fit for purpose in the 21st."[51]

Right-touch or risk-based regulation, whereby the decision about whether and how to regulate a given profession depends on the levels of risk that arise in the practice of that profession, is central to the PSA's case for change. According to the PSA:

> "Whether and how a group is regulated should not be based on how successfully or determinedly that group aspires to it. The decision should be based on what form of assurance is the right one for the nature of risk of harm that practice in question presents to the public. Statutory regulation should be preserved for those professions for whose practice it is the most effective risk management approach."[52]

The PSA recognise there may need to be a willingness to deregulate some professions, meaning they would move from statutory regulation to a system of accreditation.

[51] Health Committee, *Professional Standards Authority*, 5 July 2016, HC 301 2016-17,
[52] Professional Standards Authority, *Rethinking regulation*, August 2015

The table below outlines the key points made by the PSA.

Issue	Main arguments
No overarching design and purpose	At a time when care is becoming increasingly multidisciplinary, there is an inconsistent purpose and approach across the respective regulators. A better understanding is needed of the public value regulators are creating or protecting, the sources of legitimacy or support they need to take action and the resources organisations need to achieve the desired results.
Regulation is difficult for the public to understand	The professional regulatory system is hard to understand and navigate, as there lots of different bodies with different procedures. The language of regulation is also very technical and opaque, which has consequences for public understanding and public trust in the system.
Better understanding of risk and the appropriate regulatory approach to take	Professional regulation should be based on a better understanding of the motivations of professionals and the cultures they work in. An understanding of these components of a professional's working life would help to determine the behaviours regulators should seek to foster and the most appropriate regulatory interventions for doing so. The PSA has argued that regulators should also develop a shared understanding of the risks that they need to manage and the most appropriate methods for managing risks, along with an open dialogue with the public and registrants about the risks involved in healthcare. There is currently no coherent method or framework for deciding the level of assurance or regulation required for particular occupations, based on the hazards associated within that profession.
Need for a preventive and inquisitive approach	The PSA puts forward the case for a more preventative approach to regulation, with the aim of using insight and data from regulatory action to develop an improved understanding of the situational factors in which harm occurs and help employers and professionals to build safer working cultures and practices.

7. Recent and forthcoming reforms

7.1 Social work

The regulation of social work looks set to change in the not so distant future, as the Government has proposed to introduce a new social work regulator known as Social Work England. The *Children and Social Work Act 2017*, which was granted Royal Assent on Thursday 27 April 2017, made provisions for the establishment of this the new regulator. The Government had originally planned for the body to be operational by 2018, although it is unclear whether this remains the intention.[53]

7.2 Midwifery supervision

The Nursing and Midwifery (Amendment) Order 2017 recently removed the statutory system of supervision and local investigation unique to midwifery, along with the NMC's statutory requirement to have a Midwifery Committee. In effect, these changes now give the NMC sole responsibility for the regulation of midwives.[54]

The removal of the statutory committee sparked concern from the Royal College of Midwives (RCM) who were worried that this would reduce the voice of midwifery within the regulator.[55] The NMC has subsequently taken steps to ensure it remains well advised on midwifery issues through the creation of a strategic midwifery advisory panel and the appointment of a senior midwifery advisor.[56]

Supervision and local investigation was introduced at a time when midwives were independent practitioners responsible for home deliveries. However, as the Government argued, contemporary midwifery practice no longer justifies this additional tier of regulation and recent reviews suggest these arrangements can impede rather than protect patient safety.[57]

Dr Bill Kirkup's investigation of maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust highlighted how the separation of local supervision from other clinical governance and regulatory procedures led to friction at the trust. [58] This finding was supported by a report on midwifery supervision by the Parliamentary and Health Service Ombudsman (PHSO). Furthermore, the PHSO highlighted inherent conflicts of interests in Supervisor of Midwives Role, stemming from the mix of support and regulatory

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53 House of Commons Library, *Social Work Regulation (England)*, CBP07802, 2 December 2016
54 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, 22 February 2017
55 Royal College of Midwives, *30 days to save your midwifery committee*, 27 May 2016
56 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, 22 February 2017
57 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, 22 February 2017
58 Kirkup, B. *Morecambe Bay Investigation: report*, March 2015

oversight within the role and that fact that supervision could occur on a peer-to-peer basis.[59]

The RCM also raised concerns about the ability of local healthcare services to implement and maintain a non-statutory system of supervision in a time of constrained resources. However, the RCM has supported NHS England's decision to include a new employer-led model of midwifery supervision in its guidance to commissioners.[60]

7.3 Nursing and nursing associates

The Nursing and Midwifery (Amendment) Order 2017 also introduced long awaited changes to the NMC's fitness to practise rules, with the aim of making the process more efficient. In 2015-16, the NMC brought just over 1,700 cases before a panel, either at a public hearing or private meeting, costing the regulator more than £58 million - about 76% of the NMC's budget.[61] To address this problem, the Order has amended the NMC's fitness to practise processes to make them more efficient and proportionate.[62] These changes include an increased range of sanctions for the NMC's Investigating Committee, which enable it – in a similar way to the GMC – to agree undertakings with a registrant or issue warnings and advice. The Order has also streamlined the NMC's committees into a single fitness to practise committee.[63]

In 2015, the Government announced the creation of a new nursing associate role to bridge the gap between healthcare assistants and registered nurses. The role is currently being piloted across 35 test sites across the country, with 2000 new trainees set qualify in 2019.[64] At the request of the Secretary of State for Health, the NMC in January 2017 confirmed that it would act as the regulator of nursing associates.

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59 Parliamentary and Health Service Ombudsman, *Midwifery supervision and regulation: recommendations for change*, December 2013
60 Royal College of Midwives, *New model of midwifery supervision*, March 2017
61 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, 22 February 2017
62 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, Wednesday 22 February 2017.
63 Delegated Legislation Committee, *Draft Nursing and Midwifery (Amendment) Order 2017*, 22 February 2017
64 Nursing and Midwifery Council, Nursing associates: a new care role in the nursing family, Accessed on 26 August 2017

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