Submission from the Health and Care Professions Council (HCPC)

1. Introduction

1.1 This evidence submission includes some key information about the performance of the organisation (section two). We have also highlighted our work in three areas: extending regulation to other professional and occupational groups (section three); continuing fitness to practise (section four); and building the evidence base of regulation (section five). We have also included some statistical data (section six).

2. Information about the HCPC

2.1 The Health and Care Professions Council (HCPC) is an independent statutory regulator of 319,637 individuals across 16 health, psychological and social work professions (figure correct as at 1 November 2013).

2.2 These are: arts therapists; biomedical scientists; clinical scientists; chiropodists / podiatrists; dietitians; hearing aid dispensers; occupational therapists; operating department practitioners; orthoptists; paramedics; physiotherapists; prosthetists / orthotists; practitioner psychologists; radiographers; social workers in England; and speech and language therapists.

2.3 The HCPC was established by Parliament under the Health and Social Work Professions Order 2001. Our predecessor, the Council for Professions Supplementary to Medicine (CPSM), was established in 1961.

2.4 Our main objective is to safeguard the health and wellbeing of persons using or needing the services of our registrants and we do this by:

- setting and maintaining standards for professional skills and conduct;
- maintaining a register of professionals who meet these standards;
- approving and monitoring education programmes leading to registration; and
- taking action when a registrant’s fitness to practise falls below our standards.

2.5 We also protect professional titles, with all the professions having at least one protected title. It is a criminal offence for someone to claim to be registered when they are not, and we take action against those who do so.

2.6 In order to carry out our regulatory functions effectively we work with relevant organisations, sharing appropriate information relating to registration and fitness to practise. One way we do this is through memoranda of understanding and
such agreements are in place with a range of organisations including the Care Quality Commission (CQC) and the regulators of social workers in Northern Ireland, Scotland and Wales.

The Register

2.7 In 2012-13, we received 2,822 applications from international professionals and 16,233 applications from individuals completing UK approved programmes.

2.8 The current renewal fee is £76. At the time of this submission we had concluded a consultation to increase this to £80 from April 2014. Even with this increase, we would continue to have the lowest fee of all the nine regulators overseen by the Professional Standards Authority for Health and Social Care (PSA).

Fitness to Practise

2.9 In 2012-13, we received 1,657 fitness to practise allegations. This amounts to 0.53% of all registrants. 248 cases were concluded at a final hearing and panels imposed a striking-off order in 44 cases.

2.10 We are always looking at ways to improve the efficiency of the fitness to practise process, whilst ensuring that the public continue to be protected. In recent years this has included introducing the ability for panels to agree the disposal of suitable cases by consent without the need for a contested hearing, and the use of pre-hearing case management arrangements to ensure the timely running of hearings. In 2012-13, the mean time taken from an allegation meeting our standard of acceptance to consideration by an Investigating Committee Panel (ICP) was seven months. The mean time taken to conclusion at a final hearing was 16 months.

2.11 In its 2012-13 performance review report, the PSA concluded that the HCPC was amongst those regulators ‘managing their caseloads effectively and efficiently’.1

Education

2.12 We approve programmes which lead to eligibility to apply to our Register. We approve 872 programmes at 147 education providers (figures correct as at 25 November 2013).

2.13 We conduct visits of education providers to ensure they meet our standards of education and training. This ensures individuals completing approved programmes are fit to practise at their point of entry to the Register. Continued approval is subject to meeting our on-going monitoring requirements.

2.14 71 visits to 167 programmes are scheduled in the 2013-14 academic year.

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Professional and lay input

2.15 We work with a range of professional and lay individuals who provide expertise in our decision making for our governance and regulatory processes.

2.16 We have 634 Partners, with lay and professional expertise, who work across six regulatory functions. This includes sitting on fitness to practise panels; visiting education programmes; assessing continuing professional development profiles; and reaching decisions about applications from international applicants.

3. Extending regulation to other professional and occupational groups

3.1 We have a track record of extending regulation to further professions. Since our Register opened in 2003, we have registered four additional professions. Most recently we opened our Register to social workers in England following the abolition of the General Social Care Council (GSCC).

3.2 In 2011, the Department of Health committed that it would explore the scope for the HCPC ‘to establish a voluntary register of [adult] social care workers [in England] by 2013’.²

3.3 We have carefully considered this issue and concluded that there are significant shortcomings in a voluntary register being held by a statutory regulator. These are the lack of legal compulsion for individuals to be registered and the inability of the regulator to demand information or to compel witnesses when investigating fitness to practise allegations. Crucially, it also means that if someone was removed from a voluntary register they could continue to practise.

3.4 We consider there is the potential for public confusion around the status of voluntary and statutory registers being held by the same organisation. We have also concluded that there would be considerable costs involved in establishing such a register and paying for its operating costs until it was self-financing.

3.5 Recent estimates are that the adult social care workforce in England numbers 1.63m jobs.³ This is a large, low paid and often transitory workforce with significant numbers of part time workers. We have concluded that ‘full statutory regulation’ for this group is unlikely to be considered to be a proportionate or cost-effective response.

3.6 We have instead proposed a ‘negative registration scheme’ and statutory regulation of CQC registered managers.


3.7 A negative registration scheme would improve public protection because it would enable the regulator to deal effectively with the small number of individuals who are unsuitable to work in adult social care in England, without placing a disproportionate burden on the remainder of the workforce.

3.8 This model would work as follows.

- A statutory code of conduct would be set for adult social care workers in England.
- Employers would be expected to resolve low level complaints.
- Those cases involving more serious complaints, particularly where service users were or would be placed at risk, would be reported to the regulator for investigation.
- There would be no registration requirement. However, the adjudication process would enable those unfit to practise as adult social care workers in England to be prevented from doing so by being included on a ‘negative register’.
- It would be a criminal offence to engage in adult social care in England whilst the subject of negative registration.

3.9 The ‘negative registration’ model draws upon a similar scheme which has been successfully operated by the New South Wales Health Care Complaints Commission for a number of years and is due to be extended to other states and territories.

3.10 All providers registered by the CQC must have a registered manager for each of the ‘regulated activities’ they carry out. Some of these individuals will be from statutory regulated backgrounds, others will not. We have proposed that these managers should become statutory regulated. This will put them on the same footing as other regulated professions by having a binding code of conduct and ethics.

3.11 We consider that these proposals might be more effective than relying on purely voluntary or self-regulatory arrangements alone. They would provide an important ‘safety net’ whilst building on other sector-led initiatives focused on assuring and improving quality in this sector.

3.12 We have submitted these proposals to Government. If the Government considered that these proposals met its policy objectives, further development work would be required.\(^4\)

3.13 In addition, it is existing Government policy that we should in the future become responsible for the regulation of herbal medicine practitioners and ‘non-medical’ public health specialists.

4. Continuing fitness to practise

4.1 This section outlines our rationale and on-going work in the area of continuing fitness to practise. We use this term (in line with the approach taken in the PSA’s 2013 report on this topic) to describe the steps taken by regulators (and others) to support fitness to practise beyond the point of initial registration. This term reflects our outcomes-focused approach and avoids ‘revalidation’ which is often poorly defined.

4.2 Since 2003, we have required registrants to renew their registration every two years. Since 2006, registrants have had a compulsory, statutory requirement to undertake continuing professional development (CPD). Our standards for CPD are focused on outcomes – the benefits of CPD to services users and quality of care. These standards are linked to registration and are underpinned by random audits. We consider that auditing is a proportionate method of ensuring compliance. We can and do remove individuals from the Register where our standards have not been met. We also have in place requirements for those seeking to return to the Register after a period out of practice.

4.3 Analysis of fitness to practise allegations against registrants has shown that the majority of cases (72% in 2012-13) are about conduct and professionalism with relatively few cases purely about lack of competence. We have been undertaking a programme of work and research to build the evidence base further and inform decisions about how we approach the assessment of continuing fitness to practise.

4.4 This has included or includes the following.

- Research (2011) looking at perceptions of professionalism by both students and educators and about why and how professionalism and lack of professionalism may be identified. A further study is on-going looking at methods for measuring and tracking professionalism during training and beyond.  

- Research (2011) looking at the potential value of service user and colleague feedback tools to provide further external input on registrants continuing fitness to practise.

- More in-depth analysis of existing fitness to practise data (2012) to look at the characteristics of registrants reaching final hearings and whether there are relationships with variables such as age, gender, work setting and route to registration which might suggest clear patterns of risk.

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5 The research reports referred to in our submission can be found here: http://www.hcpc-uk.org/publications/research/
• More in-depth analysis of the content, outcomes and impact of the CPD standards and audits since 2006, including, for example, the extent to which annual appraisals and service user feedback form part of registrants’ existing CPD portfolios.

4.5 We anticipate that the outcomes of these pieces of work will inform whether and in what ways we might enhance our existing approach to assessing registrants continuing fitness to practise. For example, we might consider requiring registrants to seek service user feedback to inform their learning and we might want to consider whether we have sufficient information on risk such that we might consider targeting our audits towards ‘higher risk’ groups. We consider that it is important that any further developments in this area are evidence-based and proportionate.

5. Building the evidence base of regulation

5.1 We know that there is generally a lack of research and analysis on topics related or relevant to the regulation of the professions that we regulate. In recent years, we have particularly sought to expand the research we commission in order to contribute to the evidence base of regulation. Our work in this area is about helping us make better, more evidence-based decisions, as well as making a contribution to the wider regulatory agenda. We invest resources in dissemination of research as well as commissioning research to ensure that it has an impact on practice. Every year we hold a series of events with our stakeholders to provide a mechanism for debate.

5.2 Section four of this submission describes some of the pieces of work we have undertaken or commissioned in relation to continuing fitness to practise. We have provided some further examples below.

• Research (2010) to better understand the expectations of complainants about the fitness to practise process. This research influenced a programme of work to develop the information provided to better support and communicate with complainants and witnesses.

• Research (2011) looking at alternative methods of resolving disputes and stakeholder opinions on the potential role of mediation in the fitness to practise process. This work has informed an on-going pilot of mediation between registrants and complainants in appropriate cases as part of the fitness to practise process.

• Research (2012) looking at the extent of the involvement of service users and carers in the education and training programmes we approve. This research informed changes to our standards of education and training to require education providers to involve service users and carers in their programmes.
5.3 Our research looking at professionalism in particular has been well received by our stakeholders (see 4.4). It has made a valuable contribution to initiatives on this topic by both the Scottish Government and the Department of Health. We have also published articles in a range of professional journals and the research has been used as the basis for discussion with registrants at seminars and presentations, via events held throughout the UK and online. We consider this to be an important area of work, particularly in light of recent well documented examples of failures in care in hospitals and care homes. We have a strong commitment to encouraging registrants to think about their professional behaviour and that of others, and to place as much emphasis on this important aspect of professional practice as is already the case for competence.

6. Key operational statistics

6.1 HCPC Register by profession (at 1 November 2013)

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6.2 Registration renewal fees across the 9 regulators overseen by the PSA

![Graph showing registration fees for different regulators against number of registrants.]

Notes

- Renewal fees are for dentists (GDC); pharmacists (GPhC); and registration with a licence to practice (GMC).
- Figures correct as of June 2013.

6.3 Fitness to practise – length of cases (April 2009 – March 2014)

![Graph showing the number of cases against the length in months for different years.]

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