Education and Training Committee, 13 September 2012

Annotation of the Register – qualifications in clinical neuropsychology

Executive summary and recommendations

Introduction

We have powers to annotate the Register. These are discretionary powers and it is for the Council and the Education and Training Committee to decide whether to exercise those powers.

We consulted between 1 November 2010 and 1 February 2011 on our proposals related to post-registration qualifications and annotation of the Register. The consultation sought stakeholder's views on two different areas:

- the criteria that we will use to make decisions about whether to annotate a post-registration qualification on the Register; and
- whether we should consider annotating qualifications in podiatric surgery and clinical neuropsychology on the Register.

The Committee and Council have now agreed a policy statement setting out the principles that we will adopt in deciding whether or not we annotate a qualification on the Register. Now that we have agreed those principles, we must consider how those principles apply to the specific qualifications identified in the consultation.

This paper focuses on the qualifications in clinical neuropsychology. It provides information about practice and then looks at the evidence gathered by the Executive for and against annotation of the Register.

Decision

The Committee's decision is set out in section five of the paper.

Background information

The Committee has considered the topic of annotation of the Register and post-registration qualifications on several occasions. The Committee agreed the policy statement at its meeting on 17 November 2011: http://www.hpc-uk.org/assets/documents/1000379F20111117ETC08-post-regqualifications.pdf

Resource implications

If the Committee and Council decided to annotate the Register, this would have resource implications. Those resource implications would include consultation on standards, approval of education programmes and changes to registration systems. Depending on the Committee and Council's decisions, those resource implications would need to be included within the workplan for 2013 – 2014.

Financial implications

If the Committee and Council decided to annotate the Register, this would have financial implications. Those financial implications would include the costs of consultation on standards, approval of education programmes and changes to registration systems. Depending on the Committee and Council's decisions, those financial implications would need to be included within the budget for 2013 – 2014.

Appendices

- Appendix one – policy statement on annotation of the Register.
- Appendix two – supporting information.
- Appendix three – right touch regulation.

Date of paper

3 September 2012

Annotation of the Register – qualifications linked to practice in clinical neuropsychology[1]

1. Introduction

1.1 At their meetings in November and December 2011 respectively, the Committee and Council agreed a policy statement setting out the principles that we will adopt in deciding whether or not we annotate a qualification on the Register (see appendix one). We would consider annotating the Register where:

- there is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems;
- annotation is a proportionate and cost-effective response to the risks posed;
- the qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively; and
- preferably there is a link between the qualification and a particular title or function which is protected by law.

1.2 In our consultation on post registration qualifications and annotation of the Register, we sought the views of stakeholders on whether we should annotate qualifications in clinical neuropsychology and podiatric surgery on the Register.

1.3 The Committee and Council have now agreed that we should annotate the qualification in podiatric surgery (which is currently the Certificate of Completion in Podiatric Surgical Training) on the Register. The Executive is presenting a separate paper, setting out a timetable for this work, at this meeting.

1.4 This paper asks the Committee to consider the evidence base for annotating the qualifications in clinical neuropsychology on the Register. The Executive believes that, to date, there is insufficient evidence of risk to make a case for further regulatory intervention in this area.

1.5 It is important to note that we only have powers to annotate the Register. Decisions about whether the annotation is linked to a protected title or function are ones for government.

About this paper

1.6 Annotation of the Register is a complex area. The Committee's previous discussions have covered both the general principles around annotation of the Register and the appropriateness of annotating specific qualifications. This paper

[1] This paper uses the term 'clinical neuropsychology' as the qualification being considered for annotation is the Qualification in Clinical Neuropsychology. Our consultation in 2010 used the phrase 'neuropsychology' as that was the name used within the Department of Health's documents on the regulation of practitioner psychologists. The website of the British Psychological Society uses both terms.

focusses on making an in principle decision on annotation of the Register and does not make recommendations about implementing those decisions (which would be explored separately).

1.7 This paper looks at the evidence in support of, and against, annotating qualifications in clinical neuropsychology on the Register. Primarily that evidence is drawn from information collected during the consultation process.

1.8 The information presented in this paper is the information gathered to date, which is limited. The Executive is therefore seeking clear direction from the Committee on the evidence base and whether additional information is required before the Committee can make a decision.

1.9 This paper is divided into five sections:

- Section one introduces the paper.
- Section two explores different approaches to assessing risk.
- Section three provides information about the qualifications in clinical neuropsychology.
- Section four considers the qualification against the principles we have set for making decisions about annotating the Register.
- Section five sets out the Committee's discussion and decision.

1.10 This paper has two appendices:

- Appendix one sets out the agreed policy statement on annotation of the Register.
- Appendix two explores CHRE's right-touch regulation methodology in more detail.
- Appendix three sets out more information from our 2010 consultation on post-registration qualifications and annotation of the Register.

2. Approaches to assessing risk

2.1 Annotation of the Register only applies to already regulated individuals. The risks we mitigate through annotation are the risks of practising in an area significantly beyond a registrant's normal scope of practice where existing standards and governance arrangements are insufficient. In these cases, it may be appropriate to develop a system of annotations and set standards linked to those annotations.

2.2 We have based our approach to annotation of the Register on the principle that generally, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where we have evidence that there is a clear risk to the public if we do not annotate.

2.3 Our approach to risk should be flexible and take account of a variety of factors and different approaches. The information in the following paragraphs briefly sets out different approaches to assessing risk and considers the types of evidence that the Committee could use to make a decision on annotation of the Register.

Enabling Excellence

2.4 In February 2011, the Government published 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers'.[2] The paper sets out government policy in relation to the regulation of healthcare workers, social workers and social care workers.

2.5 The government argue that professional regulation should be proportionate and effective, imposing the least cost and complexity whilst securing safety and confidence in the professions. The government emphasises that regulators should only take on new responsibilities or roles, including developing advance practice registers, where there is '…robust evidence of significant additional protection or benefits to the public' (page 11, paragraph 2.8).

Extending professional and occupational regulation

2.6 The Department of Health set up the Extending Professional and Occupational Regulation working group in 2008, to look at recommendations on extending the scope of professional and occupational regulation. The working group's report focuses on extending regulation to new groups but makes some more general statements relevant to assessing risk.[3] The report identified key factors that could be used to assess risk. These include:

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[2] 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers', Department of Health 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359

[3] Extending professional and occupational regulation: the report of the Working Group on Extending Professional Regulation (July 2009) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102824

- the type of intervention;
- where the intervention takes place;
- the level of supervision;
- the quality of education, training and appraisal of individuals; and
- the level of experience of the individual carrying out the intervention.[4]

Right-touch regulation

2.7 In August 2010, the CHRE published 'Right-touch regulation'.[5] The CHRE define right-touch regulation as being '…based on a proper evaluation of risk, is proportionate and outcome focussed; it creates a framework in which professionalism can flourish and organisations can be excellent' (page 8, 3.1).

2.8 The concept of 'right-touch regulation' focuses on evaluation of risk. Regulation should not act in response to every concern or question of safety; instead, all parties should take responsibility for managing risk.[6] Decisions about risks posed should take account of the broader context within which the practice takes place. This includes looking at the other systems (such as clinical governance arrangements) that manage risks linked to practice.[7]

2.9 The CHRE propose an eight-step methodology for ensuring that regulation is 'right-touch'.[8] By following this methodology, regulators can ensure that the costs of regulation are worth the benefits that regulation can bring. We have explored this methodology in more detail in appendix two.

Evidence of risk

2.10 Members of the Committee have previously argued that we should assess risk based on evidence of harm, or evidence that the standards did not adequately protect the public, rather than on hypothetical risk.

2.11 The evidence base for annotation is therefore the evidence that existing systems do not sufficiently manage the risks posed by a particular area of practice **and** that the risks could be managed through annotation. We could use a variety of evidence to assess risk. Some of these are set out below, although the list is not exhaustive and not all evidence will be available for every area:

- outcomes of fitness to practise cases;
- evidence that improperly qualified individuals are practising in a particular area;
- evidence that existing governance systems are not sufficiently managing the risk;
- evidence of adverse outcomes;
- litigation data and insurance claims;
- evidence from professional bodies; and
- information from the consultation responses.

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[4] Extending professional and occupational regulation, page 8 and chapter 2

[5] 'Right-touch regulation', CHRE 2010, http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf

[6] 'Right-touch regulation', page 9, paragraph 3.7

[7] Right-touch regulation', page 8, paragraph 2.14 – 2.17

[8] 'Right-touch regulation', pages 10-12, paragraphs 4.1 – 4.8

2.11 There is no one formula for making decisions about regulation based on the risks posed by practice in a particular area. Nor is there one kind of evidence that would clearly show that the existing systems do not manage risks effectively. Instead, decisions about risk must reflect all the evidence, be reasonable and be appropriate.

3. About clinical neuropsychology

Route to training

3.1 The British Psychological Society (BPS) currently runs the Qualification in Clinical Neuropsychology (QiCN). This qualification replaced the Practitioner Full Membership Qualification.

3.2 Psychologists who complete the qualification are eligible for full membership of the Division of Neuropsychology and entry to the Division of Neuropsychology's Specialist Register of Clinical Neuropsychologists.

3.3 The QiCN has two forms:
- Adult clinical neuropsychology
- Paediatric clinical neuropsychology

3.4 Psychologists who want to enrol for the adult clinical neuropsychology qualification must meet a range of entry criteria, including:
- holding chartered membership of the Society;
- registered with the HCPC as a clinical psychologist; and
- completing a Society-accredited qualification in clinical psychology.

3.5 Psychologists who want to enrol for the paediatric clinical neuropsychology qualification must meet a range of entry criteria, including:
- holding chartered membership of the Society;
- registered with the HCPC as a clinical psychologist or educational psychologist; and
- completing a Society-accredited qualification in clinical or educational psychology.

3.6 The QiCN in either form has three key parts, knowledge, research and practice. Psychologists must undertake two years in supervised practice (more if part time) as well as eighty hours of clinical supervision before completing the qualification.

3.7 All psychologists completing the QiCN are studying via the independent route. Some may choose to pursue the knowledge and/or research dimensions through an accredited university course, but the ultimately the qualification is independent for all candidates.

3.8 A board of assessors appointed by the BPS assesses the information collected during the QiCN. The information includes essays, examination papers completed, a research report, case log and case studies. Successful completion of the assessment process results in the QiCN award.

3.9 The information above sets out the BPS's route to training as a clinical neuropsychologist. As set out below, we are aware that not all individuals working as clinical neuropsychologists in the UK completed this training. In addition, some clinical neuropsychologists have a background in other areas of psychology, such as occupational psychology.

Practice in clinical neuropsychology

3.10 Clinical neuropsychology is the study of brain-behaviour relationships and the implications of brain disease, injury or abnormal development for infants, children and adults.

3.11 Clinical neuropsychologists work with people of all ages who have neurological problems. Neurological problems could include traumatic brain injury, stroke, tumours and neuro-degenerative diseases. Their role is to help in the assessment and rehabilitation of people with brain injury or other neurological disease. Specialist knowledge of the impact of brain function helps patients and families to adapt and rehabilitate appropriately.[9]

3.12 Clinical neuropsychologists usually work in one of the following areas as part of a multi-disciplinary team:

- in acute settings, working in regional neurosciences centres; or
- in rehabilitation centres, providing assessment and support for people with a brain injury or other neurological problem; or
- in community services, providing support to those who have returned to community living following a brain injury or other neurological problem.

3.13 Part of a clinical neuropsychologist's job can include providing advice to medical and neurosurgical colleagues on the implications of removing parts of a patient's brain. Surgery might be necessary to remove a tumour or prevent progressive neurological diseases. The role of the clinical neuropsychologist is to provide expert opinion so that the surgeon does not remove a functional brain area.

3.14 Clinical neuropsychologists may also carry out medico-legal assessments and reports for the courts. They might assess brain function in relation to a case about medical negligence or a road traffic accident.

3.15 The terms 'neuropsychologist' and 'clinical neuropsychologist' are often used interchangeably and we were contacted by individuals using either title during the consultation. Often, the term 'clinical neuropsychologist' is used to describe those who work with clients, whilst 'neuropsychologist' is used to describe those involved in education or research. However, the distinction is not always clear as clinical neuropsychologists often undertake research as part of their practice.

[9] For example, the Department of Health guidelines on treating acquired brain injury in children refer to the work of a paediatric clinical neuropsychologist.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4098553

4. Annotating the qualifications in clinical neuropsychology

4.1 This section looks at the qualifications in clinical neuropsychology against the principles that we have set to make decisions about annotation.

Risk to the public

Principle: There is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems.

4.2 The Executive has worked to gather information from different sources, including responses to the consultation and information from the professional body, to assess the risks posed by practice in clinical neuropsychology but has found it difficult to identify information that shows there is a risk to the public.

4.3 Any assessment of risk needs to be holistic, rather than simply statistical, taking into account all of the factors and evidence considered below.

What do we know about risks?

We can consider risk in a number of different ways:

- risks stemming from practice in clinical neuropsychology (adverse outcomes and fitness to practise cases);
- reputational risks for ourselves if we are not perceived to be taking action in this area; and
- risks stemming from a lack of publicly available information about the qualifications of individual clinical neuropsychologists.

Adverse outcomes

4.4 Examples of adverse outcomes from the practice of clinical neuropsychology can include misdiagnosis or incorrect assessment or support given on how to treat neurological problems. In cases where a clinical neuropsychologist is providing advice to surgical or medical colleagues prior to neurosurgery, adverse outcomes could include the unnecessary removal of functioning brain tissue.

4.5 When the Committee considered the case for annotating the qualification in podiatric surgery on the Register, the Executive provided quantitative information about the potential for adverse outcomes when a surgical intervention was carried out.

4.6 The Executive has not been able to identify quantifiable evidence of adverse outcomes stemming from the practice of clinical neuropsychology. However, the Executive is aware of some limited anecdotal evidence of adverse outcomes. This anecdotal evidence is related to situations where a patient with neurological problems did not receive assessment and support from a clinical neuropsychologist.

Fitness to practise cases

4.7 In 2010-2011, we received 118 cases against practitioner psychologists on our Register. In the same period, nineteen cases were considered at final hearing, of which 11 were not well founded.[10]

4.8 To date the Executive has not identified a fitness to practise case considered at a final hearing where a clinical neuropsychologist had concerns raised about their practice.

Reputational risk and public perception

4.9 When the previous government consulted on the regulation of practitioner psychologists, one issue that came out of the consultation was around the regulation of neuropsychologists.[11] Some clinical neuropsychologists who responded to the consultation were in favour of creating an additional domain for clinical neuropsychologists, under the practitioner psychologist part of the Register.

4.10 At the time, the previous government recognised that most clinical neuropsychologists have completed the clinical or educational psychology training, before completing additional training to become a clinical neuropsychologist (although they did recognise that not all clinical neuropsychologists had trained in this way). They said that it would be open to us to recognise clinical neuropsychologists' post-registration specialism through an annotation on the Register, once we had taken on the regulation of practitioner psychologists.

4.11 As a result of these comments, there may be a reputational risk if we do not take action to annotate the Register. However, the Executive believes that the risk is small as the previous government made clear that whether we chose to annotate the qualification was our decision.

4.12 Another potential risk is around whether there is sufficient information in the public domain to allow members of the public or employers to check the qualifications of a clinical neuropsychologist. The Division of Neuropsychology's Specialist Register of Clinical Neuropsychologists is publicly available and individuals can search for information about a clinical neuropsychologist's

[10] Fitness to practise annual report 2011, http://hcpc-uk.org/assets/documents/10003700FTPannualreport2011.pdf. It should be noted that the 19 cases considered at final hearing might include cases that were received before the period covered in the annual report and some of the cases we received in 2010-2011 may have been concluded after that period.

[11] Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009: consultation report http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_095923

qualifications and areas of experience.[12] The Register currently holds approximately 390 members.

How are the risks of practice currently managed?

4.13 The risks of practice are currently managed in several different ways:

- The majority of clinical neuropsychologists will be HCPC registrants, registered as either clinical or educational psychologists.
- We can consider concerns raised about the practice of clinical neuropsychologists if they are on our Register.
- Clinical neuropsychologists working in the NHS must adhere to the NHS's standards and clinical governance frameworks.
- The Division of Neuropsychology encourages employers to employ clinical neuropsychologists who are members of the Division's Specialist Register.

How might annotation improve the way in which risks are managed?

4.14 Annotation would improve the way in which risks are managed because:

- It allows us to set standards above the threshold level for specific areas of practice.
- We can approve the education programmes linked to the annotation, thereby providing external quality assurance of training.
- Annotation provides information to members of the public, supporting choice.
- We can consider cases about a registrant's fitness to practise in the area annotated with reference to standards we have set for that area of practice.

Annotation is proportionate and cost-effective

Principle: Annotation is a proportionate and cost-effective response to the risks posed.

4.15 The Committee has already agreed that we will only annotate the Register in exceptional circumstances and that the decision to annotate must be proportionate and cost-effective.

4.16 This paper does not look specifically at the costs associated with deciding to annotate the Register. However, the costs would include those linked to setting standards and approving education programmes. The route to training is set out in paragraphs 3.1 – 3.9 above. There would be a low number of programmes to approve, reducing the cost implications of the decision to annotate the Register.

4.17 One way of deciding whether annotation is proportionate and cost-effective is to follow the CHRE 'Right touch regulation model' (see paragraphs 2.7 – 2.9 above). We have explored this model in appendix two of this paper.

[12] http://www.bps.org.uk/bpssearchablelists/SRCN

The qualification is necessary for practice

Principle: The qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively.

4.18 Some respondents to the consultation argued that the qualification in clinical neuropsychology offered by the BPS was essential to safe and effective practice as a clinical neuropsychologist. This was because the qualification ensured that clinical neuropsychologists developed the skills necessary for practice.

4.19 However, other respondents to the consultation argued that the qualification delivered by the BPS was not necessary for practice as a clinical neuropsychologist. They commented that individuals were practising safely in this area of practice without completing the qualification, having developed the skills and knowledge in other ways. Alternatively, other respondents to the consultation commented that other professionals, including other psychologists, could also complete some tasks carried out by clinical neuropsychologists.

The qualification is linked to a function or title

Principle: Preferably there is a link between the qualification and a particular title or function which is protected by law.

4.20 Currently, psychologists who complete the QiCN are eligible to join the BPS' register of clinical neuropsychologists. There is therefore a link between the qualification and a title that could be protected.

4.21 However, a number of respondents to the consultation raised concerns that annotating the qualification would mean that other individuals, who do not have the BPS's qualification, would not be able to practise as a clinical neuropsychologist. Other respondents argued that the model of annotation, based on completing the clinical or educational psychology doctorate before completing the QiCN, was discriminatory to other psychologists who worked as clinical neuropsychologists but did not have the initial training and therefore could not be annotated.

5. Discussion

5.1 The government argued in Enabling Excellence that regulators should only develop advanced practice registers where there was robust evidence of significant additional protection or benefits to the public (see paragraph 2.5 of this paper).

5.2 Any assessment of risk is subjective, but CHRE's right-touch regulation methodology is a useful tool to explore whether the proposed intervention is proportionate to the risks posed. The Executive has worked through this methodology in appendix two of this paper.

5.3 The Executive has found limited evidence of risk linked to the practice of clinical neuropsychology. For example, the Executive has not identified any fitness to practise cases related to clinical neuropsychologists, nor has any quantitative information on adverse outcomes. The risks of practice are currently managed in the following ways:

- Most clinical neuropsychologists are HCPC registered clinical or educational psychologists. Some may be HCPC registered in other domains.
- The BPS already holds a register of psychologists who have completed the QiCN and this information is available to members of the public.
- Those clinical neuropsychologists working in the NHS are already subject to clinical governance and other systems.

5.4 Any regulatory intervention must be proportionate to the risks posed by practice. Some respondents to the consultation argued strongly that annotation was a disproportionate response and would adversely affect their practice and the accessibility of clinical neuropsychology services.

5.5 The Committee is invited to discuss the information above and the information presented in appendix one, two and three. The Committee is then invited to make a recommendation to Council about whether the qualification in clinical neuropsychology should be annotated on the Register.

5.6 If the Committee feels that the information is insufficient, the Executive seeks the Committee's clear direction on what additional information the Executive could supply to support the Committee's decision making.

5.7 The Executive believes that, to date, there is insufficient evidence of risk to make a case for further regulatory intervention in this area.

Appendix 1 - policy statement on annotation of the Register

1.1 We are the Health Professions Council (the HPC). This policy statement sets out our broad approach to annotation of our Register. We have written this policy statement drawing on information we gathered following a public consultation.

1.2 In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where we have evidence that annotation is necessary to protect the public and where we believe that annotating the Register is the only mechanism that could improve public protection.

1.3 This statement does not apply to situations where we are legally required to annotate the Register.

1.4 We have discretionary powers to annotate the Register. This statement does not limit our discretion to annotate the Register. Instead, we will have regard to the principles set out in this statement when making decisions about whether or not we annotate our Register.

1.5 Please contact the Policy and Standards Department (policy@hcpc-uk.org) if you have any questions about this statement.

About annotation of the Register

1.6 We have powers to annotate our Register.[1] We annotate our Register to indicate where a registrant (someone on our Register) has undertaken additional training around medicines and has obtained entitlements to supply, administer or prescribe these medicines. We are required to do this by legislation called 'The Prescriptions Only Medicines (Human Use) Order 1997'. We therefore only currently annotate the Register where there is a legal requirement to do so.

1.7 In each of these cases, individuals can only practice in a particular area if they have the annotation on our Register. For example, a physiotherapist can only act as a supplementary prescriber if they have completed the appropriate training and have their entry on our Register annotated.

1.8 We annotate qualifications on the Register. The term 'qualifications' does not only mean those formal qualifications delivered by higher education institutions, but instead means any type of learning which has an assessment process at the end. The assessment process means that the provider can check that the registrant has the necessary skills and we can be confident that the individual has successfully attained a package of skills and knowledge meaning that we can annotate their entry in the Register.

[1] These powers are set out in the Health Professions Order 2001 ('the Order') and in the Health Professions Council (Parts and Entries in the Register) Order of Council 2003 www.hpc-uk.org/publications/ruleslegislation/.

Broad principles on annotation of the Register

2.1 We believe that in most cases, existing systems, including our standards and processes, manage the risks posed by our registrants' practice. We do not therefore need to take additional action to manage those risks.

2.2 In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where there is evidence that we can improve public protection in a specific area by annotating a qualification.

2.3 Annotating the Register means that we can set standards for a particular area of practice and approve the education programmes delivering training linked to that area of practice. We would consider annotating the Register where:

- there is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems;
- annotation is a proportionate and cost-effective response to the risks posed;
- the qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively; and
- preferably there is a link between the qualification and a particular title or function which is protected by law.

2.4 Protection of titles and functions is a matter for government and where we consider that it is appropriate, we may proceed with annotation and then seek government approval for the protection of the associated title or function.

2.5 Our rationale for setting out these broad principles is set out below.

Annotation only in exceptional circumstances

2.6 We believe that the role of the regulator is to set standards for practice and identify discrete areas where additional standards may be necessary. It is not our role to provide a list of all post-registration qualifications or training which a registrant may have completed.

2.7 We will therefore only annotate the Register **in exceptional circumstances**.

Proportionality and cost-effectiveness

2.8 Annotation, as a mark on our Register, only applies to professionals already registered and subject to our standards. Any decision to annotate the Register should be a proportionate and cost-effective action, to minimise the burden on registrants.

Annotation and risk

2.9 We will only annotate a qualification on the Register where there is a clear risk to the public if we did not annotate and if we could mitigate the risk through annotation and not through other processes.

2.10 We recognise that decisions about risk can be subjective and that it can sometimes be difficult to make decisions about the levels of risk posed. There is no one formula for making decisions about regulation based on the risks posed by practice in a particular area. Decisions made about risk should be reasonable, appropriate and informed by best practice but there is no absolute way of defining these decisions.

2.11 However, assessments of risk can draw on a number of factors including:

- the nature of the intervention;
- the environment within which the intervention is carried out; and
- existing mechanisms for managing the risks posed by the intervention.

The link between annotation and an area of practice

2.12 Annotations show where a registrant has completed specific qualification and where the registrant is therefore able to practise in a particular area. Therefore, there needs to be a clear link between the qualification and either a particular function or role. It should only be possible to undertake that function or role after completing the qualification that we annotate on the Register.

2.13 Some qualifications, whilst necessary for a particular role and required by an employer, are not necessarily relevant to public safety. In those cases, there is a distinction to be drawn between our requirements as a regulator setting national standards for practice in a profession and the requirements made by an employer for a particular role.

2.14 Normally, we would prefer to exercise our powers to annotate the Register only where there is a defined title or function that could be protected by law, so that only those who meet the necessary standards are able to practise in a particular area.

2.15 Protection of a title or function requires a change in the law and such decisions are a matter for government and not for us. We can make decisions about which qualifications to annotate but can only recommend to government that a particular title or function associated with that qualification is protected by law.

Appendix two – Right-touch regulation

1.1 This appendix explores CHRE's Right-touch regulation methodology as a way of exploring whether the decision to annotate the Register is appropriate and proportionate (see paragraphs 2.7 – 2.9 of the main paper).

1.2 The CHRE has identified eight elements that support right-touch regulation in practice. We have set these out below and briefly explored these in relation to annotation of the Register. The information in this paper is not exhaustive, but provides additional information to support the Committee's decision-making.

1) Identify the problem to be resolved before identifying the solution.

1.3 Clinical neuropsychologists are psychologists who have extended their scope of practice to allow them to become involved in helping in the assessment and rehabilitation of people with brain injury or other neurological disease.

1.4 Some clinical neuropsychologists will be HCPC registered clinical or educational psychologists. However, other clinical neuropsychologists will not be HCPC registered. In addition, other psychologists work under the title 'neuropsychologist'.

1.5 In 2009, the previous government consulted on the regulation of practitioner psychologists. Some respondents to the government's consultation commented on the regulation of neuropsychologists. In their document summarising responses to the consultation, the government said that decisions around annotation were a matter for us.

1.6 The potential problem is therefore that there is an expectation amongst some stakeholders that we will annotate the Register with this qualification.

1.7 However, many of the risks associated with their practice are already managed through various systems (such as the BPS's Register of Clinical Neuropsychologists). It is therefore difficult to identify the problem to be resolved based on risk.

2) Quantify the risks associated with the problem.

1.8 Decisions about risk are subjective and it is not always possible to quantify risk in a statistical way.

1.9 We have provided information on the risks associated with practice in paragraphs 4.2 – 4.12 of the main paper.

1.10 As can be seen from those paragraphs, it has been difficult to find objective evidence of risks associated with this issue. This includes risks stemming from the practice of clinical neuropsychologists as well as risks stemming from

unregulated individuals practising as clinical neuropsychologists. It is therefore very difficult to quantify the risks associated with the problem.

1.11 Some respondents to the consultation argued that we should annotate the qualifications in clinical neuropsychology because clinical neuropsychologists work with vulnerable individuals and need considerable additional training to practise safely and effectively.

1.12 However, other respondents to the consultation raised serious concerns about the impact that annotation would have on their practice and on service delivery. This included concerns that they would no longer be able to practice and that the model of annotation was inflexible. In turn, this risked a reduction in the number of clinical neuropsychologists able to provide services to the public.

3) Get as close to the problem as possible.

1.13 This element focuses on identifying the context of the problem. This includes looking at the different levers and tools that may tackle particular issues (for example, regulatory or governance structures).

1.14 Most clinical neuropsychologists are HCPC registered as either clinical or educational psychologists. However, they do not need to be HCPC registered to practise using that title. During the consultation we were contacted by several neuropsychologists who were not HCPC registered at all, or were HCPC registered in a different domain (such as occupational psychology).

4) Focus on the outcome – improving public protection.
5) Use regulation only when necessary.

1.15 In our policy statement setting out our approach to annotation, we say that:

> ‘In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where there is evidence that we can improve public protection in a specific area by annotating a qualification.’ (paragraph 2.2).

1.16 These principles underpin our approach to annotation and help us to make sure that we focus on the outcome and only annotate where necessary.

6) Keep the solution simple so that stakeholders can understand it.

1.17 Annotating the Register is a reasonably simple solution. Members of the public would be able to check easily that their clinical neuropsychologist was HCPC registered and had completed the training.

1.18 Stakeholders would also be able to see that there were externally agreed standards for practice, the training had been independently assured and that the qualification had been annotated appropriately.

1.19 Whilst we have powers to annotate our Register, we do not have powers ourselves to protect a professional title linked to that annotation. Therefore, we could not protect the title ‘clinical neuropsychologist’ ourselves so that only individuals with the annotation could access the title.

1.20 Anecdotal evidence from the consultation shows that some individuals practise as clinical neuropsychologists or neuropsychologists without completing the BPS' training.

1.21 Those individuals would continue to be able to practise without being HCPC registered. It is therefore possible that the annotation could cause confusion to members of the public.

1.22 In addition, the Division of Neuropsychology have established a Specialist Register of Clinical Neuropsychologists who have completed the training offered by the British Psychological Society (see paragraph 4.12 of main paper). The Specialist Register is publicly available and provides information to the public about the qualifications and experience of a clinical neuropsychologist.

7) Check the impact of the solution, including whether it will have unforeseen consequences.

1.23 We asked respondents to the consultation to comment on the feasibility of annotating qualifications in clinical neuropsychology.

1.24 As set out above, we received a number of responses to the consultation from individuals who did not have the qualification in clinical neuropsychology. Those individuals were concerned that the annotation would prevent them from being able to practise. They also argued that the BPS' model of qualification would unfairly limit access to the annotation. Those respondents therefore, raised concerns that any decision to annotate the Register could adversely affect the provision of clinical neuropsychology services.[1]

1.25 We would need to consider further the impact of any decision to annotate the Register, as part of our process to implement that decision.

8) Review the solution and revise where appropriate.

1.26 It is only possible to follow this step once a decision has been made to annotate the Register.

[1] Appendix three contains a summary of the responses we received to the consultation.

Appendix three – Responses from the consultation

1.1 We consulted between November 2010 and February 2011 on post-registration qualifications and annotation of the Register.[1] This appendix provides a summary of responses we received to that consultation in relation to annotating qualifications in clinical neuropsychology on our Register.

1.2 We asked several questions in the consultation about annotating clinical neuropsychology on the Register. We have set out the relevant questions below, alongside a summary of the responses we received.

Do you agree we should annotate these qualifications?

1.3 Some respondents agreed that we should annotate clinical neuropsychology on the Register. They gave the following reasons for annotation:

- Annotation would allow the regulator to do more to manage the risks posed by practice in a particular area.
- The qualifications meet the criteria that we are proposing to use in deciding whether we annotate a qualification.
- HCPC could then set standards for practice in that area which registrants would have to meet and this would improve public protection.
- Annotation would provide increased information for members of the public and professionals about registrants who had extended scopes of practice.
- Clinical neuropsychology needs additional specific training which is not provided at a pre-registration level. The additional training needs to be recognised and approved by HCPC, it would only be possible to do this if HPC annotated the qualification.

1.4 However, a number of respondents disagreed with our proposals to annotate the Register with clinical neuropsychology:

- The qualification did not meet the criteria we were developing to make decisions about annotating the Register. In particular, there was insufficient evidence provided of the risks posed by practice.
- Some individuals practise as (clinical) neuropsychologists without the BPS clinical neuropsychology qualification. They would not be able to be annotated and could end up being stopped from practising if we decided to annotate the Register.
- Clinical neuropsychology practice is not limited to individuals who have completed the BPS' qualifications in clinical neuropsychology. A decision to annotate could stop those individuals from continuing to offer those services, when they are currently practising safely.
- It was unnecessary to introduce additional regulation as the qualifications could only be accessed by individuals who were already regulated.

[1] Consultation on our proposals for post-registration qualifications
http://www.hcpc-uk.org/aboutus/consultations/closed/index.asp?id=112