

PART 4

GOVERNANCE

Question 4-1: Should the statute: (1) reform the existing structure to encourage Councils to become more board-like; and/or (2) reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors; and/or (3) establish a unitary board structure which would move away from a two-tier approach based on a Council and officials?

- 4.1 This question divided opinion at consultation. Most consultees expressed equivocal positions. For example, the Department of Health remained open as to the most appropriate structure but was “initially inclined” towards option two. The Scottish Government was also “undecided” but was inclined towards option two followed by option three. Whichever option is agreed, It argued there should be consistency across the regulators, whichever option is adopted.
- 4.2 Both the Department of Health and the Scottish Government argued that a Council’s purpose should be to:
- (1) provide strategic direction;
 - (2) provide a point of public accountability; and
 - (3) exercise scrutiny over the exercise of powers by officials of the organisation, in particular by providing a first point of appeal in certain circumstances (for example, in relation to decisions not to accept an application for restoration to the register).
- 4.3 The Department of Health, Social Services and Public Safety for Northern Ireland suggested that the structures “need to reflect the size of the organisation to some extent”. It expressed a preference for “some separation of Council from executive allied to accountability”.
- 4.4 Of those who did express a preference, most favoured options one and three.¹

Option one: reform of the existing structure

- 4.5 Many preferred this option as it reflected the existing arrangements. For example, the General Pharmaceutical Council felt that the current system is “well established, understood well by our stakeholders with a transparent separation between Council members and the executive”. It was also reluctant to undertake any “significant structural change so soon after establishment”.² The Association of Regulatory and Disciplinary Lawyers agreed that these features weighed in favour of option one. The General Dental Council described option one as

¹ Of the 192 submissions which were received, 55 expressed a view on this question: 18 supported option one, 5 supported option two, 11 supported option three, whilst 21 held equivocal positions.

² The General Pharmaceutical Council was created in 2010, replacing the Royal Pharmaceutical Society of Great Britain as the regulator.

“viable” and one which “could be made to work even better with smaller Council sizes”.

4.6 The Professional Standards Authority was attracted to option one because it:

- (1) allows for separation of operational and strategic perspectives;
- (2) makes explicit the role and responsibility of the board to be strategic and hold the executive to account;
- (3) allows for board sizes that deliver optimal performance; and
- (4) allows for the interests of key stakeholders to be included, but also respects the increasing professionalism of regulatory staff.

4.7 The Pharmaceutical Society of Northern Ireland supported this option because the alternatives “blend strategy and delivery and the accountability is less clear between the parties”.

4.8 Some consultees thought that option one provided the necessary flexibility. The Royal College of Surgeons of Edinburgh and the Medical Defence Union both felt that regulators should be able to adapt the governance framework to their individual circumstances.

Option two: a statutory executive board

4.9 The Medical Protection Society argued that option two would provide “an appropriate separation of functions and powers”, and pointed out that this model had been implemented informally by the General Dental Council “with the executive creating a tightly knit team of directors and a policy advisory committee consisting of the executive and some Council members”. This committee develops policy and the Council is expected to act “essentially as non-executive directors commenting upon and approving policy”. Others favoured this option on the basis that it would provide a governance structure in line with other corporate organisations and health bodies.

4.10 However, several consultees were critical of option two. The General Pharmaceutical Council felt it would not command the confidence of the professions and provided a “reduced level of public accountability and fewer checks and balances in the system”. The Nursing and Midwifery Council discounted this option on the grounds that it would not provide sufficient safeguards “in the event of an ineffective relationship between the chair and the chief executive”. The General Dental Council felt that a scrutiny role for the Council could be “unrewarding” and might attract fewer applicants. The Professional Standards Authority described this as the “least attractive option” since it “defines how the executive should organise itself and would be inappropriate in smaller regulators”.

Option three: a unitary structure

4.11 The support for option three was often based on its perceived efficiency. For example, the British Association for Counselling and Psychotherapy felt that it would “maximise efficiency, ensure faster decision making and cooperation”. The Professional Standards Authority argued that the unitary board structure “has

been found to deliver well” and that unitary boards “would also establish that it is the organisation that is the regulator not the Council”. The Institute of Biomedical Science argued that the use of non-executive directors would provide “a more representative breadth of expertise”.

- 4.12 However, an individual consultee (Jane C Hern) argued that it is vital to maintain the Council/staff separation so that the staff are able to offer:

wholly impartial advice so that the strengths and weaknesses of any proposal can be fully considered and once the policy is determined, to implement it to the best of their ability.

- 4.13 A number of consultees felt that the unitary model provides insufficient oversight since board members are naturally closer to the executive as the management is sitting on the board alongside non-executives.

Other comments

- 4.14 Many argued for flexibility. For example, the General Medical Council supported option one on the understanding that “the legislative structure should allow Councils or governing boards the scope to consider other options at a later date”. The Nursing and Midwifery Council also suggested that each regulator should be able to “establish a model that suits its particular situation and have the flexibility, if necessary, for that to evolve over the years to meet any changing needs”. The General Osteopathic Council also wanted the freedom to determine which model would be most suitable, following the outcome of its current governance review. An individual consultee (Anonymous) was “concerned that putting anything in statute on governance arrangements would inhibit modernisation”.
- 4.15 Several responses suggested that the consultation paper had over emphasised structural issues. For example, the General Pharmaceutical Council stated that:

The competence, values and behaviours of those involved (whatever the structure) are likely to have a much greater impact on the effectiveness, efficiency and accountability of the regulators than the seemingly endless quest for some ideal governance structure.

- 4.16 Similarly, the Health and Care Professions Council argued that good governance depends less on “the form a governing body takes” and more on “having a strong, values driven Board, recruited against competencies with strong allegiance to the Nolan principles of public life”. The Professional Standards Authority argued that even under a common approach to governance structures, the performance of different regulators “var[ies] substantially”. It said that:

While structure is important it is unrealistic to rely on this as the major determinant of good organisational performance and delivery of regulatory obligations for wider society. Competent and skilled Council members and executives are essential.

Provisional Proposal 4-2: The statute should establish each Council as a body corporate. The regulators should continue to be able to apply to become registered with the Charity Commission if they wish to do so.

- 4.17 The vast majority agreed with this proposal.³
- 4.18 Most consultees did not elaborate on their reasons for supporting the proposal that Councils should be established as body corporates.
- 4.19 The General Optical Council suggested that:

rules around the constitution of Councils is one of the areas in which the Government may have a legitimate oversight interest, as currently provided by means of Privy Council approval. There may be risks that public confidence in the regulators could be damaged if there is a perception that Councils are able to change their key constitutional arrangements to suit the interests of their current members without checks and balances.

- 4.20 A number of responses pointed out that the statute also needed to cover registration with the Office of the Scottish Charity Regulator and the Charity Commission for Northern Ireland.
- 4.21 Several regulators commented on the issue of registration with the Charity Commission. The Nursing and Midwifery Council said:

We support the proposal that each Council should be a body corporate. The Nursing and Midwifery Council is already registered as a charity but we have no views in relation to the other regulators. However, it should be noted that the Charity Commission may have a view on this. It should also be noted that the Unitary Trust Board model might have an impact on charitable status, as a charity's employees cannot usually serve as management board members or governors.

- 4.22 The Health and Care Professions Council commented:

We have previously considered the possibility of seeking charitable status but, after some preliminary investigation, decided not to explore this further as we consider that we do not perform any charitable functions.

- 4.23 The British Association for Counselling and Psychotherapy queried whether "this could lead to a conflict of interest and treble accountability to the Professional Standards Authority, the Government and the Charity Commission".

Provisional Proposal 4-3: The statute should require that each Council must be constituted by rules issued by the regulators.

- 4.24 An overwhelming majority agreed that the statute should require that each Council must be constituted by rules issued by the regulators.⁴ For example, the

³ Of the 192 submissions which were received, 34 expressed a view on this proposal: 33 agreed, whilst 1 held an equivocal position.

Wales National Joint Professional Advisory Committee said that it was “sensible to have the make up of the body stipulated by regulators”.

4.25 However, many consultees expressed concerns. The Professional Standards Authority argued that the statute must direct the nature and content of the rules and there must be limits to the flexibility given to the regulators in their governance structures.

4.26 Similarly, the Health and Care Professions Council argued that the constitution of a Council is “fundamental in underpinning good corporate governance” and therefore should not be left entirely to the discretion of the regulator. In particular, it pointed to the potential risk of inconsistency and pressure from stakeholder groups such as professional bodies to amend the constitution. The Council argued that the regulators should only have powers to issue rules on the following:

- (1) the appointment of Council members and chairs;
- (2) terms of office;
- (3) duration of membership;
- (4) quorum for meetings;
- (5) education and training of Council members; and
- (6) attendance requirements.

4.27 In contrast, the following should be provided for in legislation:

- (1) the size of the Council;
- (2) the requirement for parity between registrant and lay members;
- (3) a requirement for Council members to be appointed from the four countries of the UK; and
- (4) provisions for the disqualification, suspension and removal of members.

4.28 The General Optical Council stated that:

There may be risks that public confidence in the regulators could be damaged if there is a perception that Councils are able to change their key constitutional arrangements to suit the interests of their current members without checks and balances. Some form of oversight of regulators’ constitutions would also help ensure that an appropriate degree of consistency in constitutional arrangements is in place across the regulators, while flexibility in the details is also maintained.

⁴ Of the 192 submissions which were received, 31 expressed a view on this proposal: 28 agreed, whilst 3 disagreed.

4.29 Others felt that Government should have an enhanced oversight role. The General Social Care Council argued that the Secretary of State should be required to approve the rules governing the constitution of the Council or have powers to issue binding guidance on these rules. The General Dental Council agreed that all constitutional arrangements should be subject to Government approval. Some consultees argued that there should be also be a mechanism to require input by the devolved administrations.

4.30 The Department of Health, Social Services and Public Safety for Northern Ireland did not comment specifically on this proposal but made a general comment that:

There is a need for Government to act on behalf of the people; while more and more power is ceded to a regulator it feels more and more like self-regulation and that would be a retrograde step.

Provisional Proposal 4-4: Each regulator should be required to issue rules on the appointment of Council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of Council members, and attendance requirements of Council members.

4.31 A large majority agreed with our proposal on which matters must be addressed by the rules.⁵ For example, the Royal College of Surgeons of Edinburgh considered that the proposal represented “good governance”.

4.32 The General Medical Council also argued that the rules should avoid detail and prescription in some areas, such as the content of training programmes for Council members. The General Social Care Council thought that the rules should not cover the quorum for meetings.

4.33 The Department of Health supported the proposals but “within certain parameters, for example parity between lay and registrant membership”.

4.34 UNISON argued that certain core elements – appointments, term of office, remuneration and disqualification – must have a level of consistency across the regulators. The Scottish Government agreed that “this is an area where there is likely to be a degree of commonality across the regulators and one in which consistency of approach would be warranted”.

4.35 Several consultees were uncomfortable about the regulators determining their own appointment processes. The British Dental Association supported a single appointments mechanism for all the regulators, “independent of, but administered by, the Professional Standards Authority”.

4.36 Several consultees agreed that the statute should require that at least one Council member must work or live in each of Northern Ireland, Scotland and Wales. However, it was also recognised that this might be difficult in the context

⁵ Of the 192 submissions which were received, 42 expressed a view on this proposal: 34 agreed, 4 disagreed, whilst 4 held equivocal positions.

of smaller regulators. The General Osteopathic Council felt that while appointments from each country in the UK would be difficult to justify in a smaller regulator, it would be important for the larger regulators “particularly where national health services may differ considerably”. The Scottish Government supported “the continued approach that at least one member of each Council should live or work in Scotland, England and Wales” but beyond this, the regulators should have discretion to “set requirements for national/regional based appointments to their Councils if they so wished”.

Question 4-5: Is an additional form of oversight required over the appointment of the General Council members? For example, should the Government have powers to remove members in certain circumstances?

- 4.37 A small majority agreed that additional oversight was required.⁶ For example, the Scottish Government argued that “the Government and, where applicable, the Scottish Government” should have powers to remove Council members in order to ensure effective leadership or prevent organisational failure.
- 4.38 Some felt that Government had a role to play. For example, the Patients Association suggested that the Secretary of State should have powers to intervene and to remove members of Councils where there has been a failure of effective leadership. The Association pointed to recent events at the Nursing and Midwifery Council where “problems with strategic leadership have hampered the regulator’s ability to perform its duties”. Rescare argued that the Government should have the power to remove Council members in “grave or extreme circumstances”.
- 4.39 The Department of Health argued there should be an order-making power vested in the Privy Council to remove members if, for example, “they are failing to meet their duties to a standard that the public and professionals have the right to expect”.
- 4.40 However, several consultees were concerned that additional Government oversight would allow for political interference in the way regulators are run. An individual consultee (Lucy Reid) stated that:

Government powers and oversight may not necessarily enhance the public confidence and there is a risk that the Councils will then be seen to be political bodies and/or may be vulnerable to political influence or policy.

- 4.41 The General Optical Council felt that a Government power to directly remove individual members was unnecessary as other safeguards would be in place, including Government intervention powers where a regulator is failing to deliver its statutory functions. However, the Council felt that Government oversight would be beneficial in respect of the “rules around the constitution of Councils”.

⁶ Of the 192 submissions which were received, 55 expressed a view on this question: 32 said that additional oversight was required; 20 consultees disagreed; whilst 3 held equivocal positions.

- 4.42 Some consultees felt that oversight should be provided by the Professional Standards Authority. For example, Coventry and Warwickshire Partnership Trust argued that the Authority should be tasked with “ensuring a consistent approach to these rules and regulations to ensure a fair approach and a role to overview the application of the rules”.
- 4.43 However, the General Pharmaceutical Council argued that it would not be appropriate for the Authority to be given a role since it does not have the necessary independence. The General Medical Council and the Health and Care Professionals Council felt that the Authority’s role should be limited to setting standards.
- 4.44 Several consultees argued that, rather than establishing greater oversight, the new system should ensure that appointments are made independently or at arms-length from the Council. Many responses contained strong statements of support for the role of the Appointments Commission and argued it would be deleterious if these benefits were lost. For example, the General Pharmaceutical Council argued that the current system provides “effective scrutiny, independence, transparency as well as quality of process”. It suggested that the Commissioner for Public Appointments or the Civil Service Commissioner, or an independent body set up by the regulators themselves, could be used in the place of the Appointments Commission. Furthermore, it noted that there remains an argument for retaining a role for the Privy Council in affirming appointments.
- 4.45 The Professional Standards Authority felt that additional oversight could be provided by the Commissioner for Public Appointments. The Patients Association argued that, at the very least, the chairs should be independently appointed under “recognised public appointments norms”. The Scottish Government argued that the “good practice exemplars that have emerged from the involvement of the Appointments Commission [should be] retained” and the Professional Standards Authority should continue to have responsibility for guidance and standards setting.
- 4.46 The Department of Health wanted to explore the need for further oversight with the Professional Standards Authority and the regulators.
- 4.47 Some consultees argued that no additional oversight is needed over the appointment of Council members. For example, the Nursing and Midwifery Council felt that “as long as the standards set by the Professional Standards Authority are adhered to” and “there is a path for concerned individuals to question the appropriateness of members remaining in post”, additional Government powers are unnecessary. This position was also supported by many of the regulators including the General Medical Council, the General Chiropractic Council and the General Osteopathic Council.

Question 4-6: Should: (1) the statute specify a ceiling for the size of the Councils of and the proportion of lay/registrant members; or (2) the Government be required to specify in regulations the size of Councils and the proportion of lay/registrant members; or (3) the regulators be given general powers to set the size and composition of their Councils and the Government be given default powers to intervene if this is necessary in the public interest?

4.48 Opinion was divided on this question. Most supported option three.⁷

Option one: upper ceiling and composition set in statute

4.49 The Royal College of Surgeons of Edinburgh supported this option, arguing that:

The use of a ceiling would seem to be the correct approach and one that chimes with the overall aims of imposing increased consistency whilst also allowing flexibility to allow regulators to respond to changing circumstances.

4.50 The Professional Standards Authority also supported this option but on the basis that “Councils are kept small and lay members have a majority”. The Medical Schools Council argued that if this option is adopted, the ceiling for Council membership should be closer to 16 than eight. The Northern Ireland Practice and Education Council for Nursing and Midwifery argued that the statute should not only specify a ceiling but also a minimum number of Council members.

4.51 Several professional bodies argued that registrants should be in the majority on Councils and membership should comprise of at least one professional from each of the professions regulated by the Council. Moreover, the Medical Schools Council argued that the statute should also recognise the importance of clinical academic input in terms of composition.

4.52 Most consultees who opposed this option felt it was too inflexible and argued that the statute should allow the development of future policy – which may not be in favour of smaller Councils and equal lay and registrant membership.

4.53 The Nursing and Midwifery Council argued that rather than specifying the proportion of lay and registrant members, the statute should be expressed in terms of principles, such as “the number of registrant members should not outnumber the number of lay members”. It was felt this would allow more flexibility to ensure that where there is a specific skills gap (such as financial expertise) a lay person could be appointed over a registrant.

Option two: size and composition set in Government regulations

4.54 Many supported this option on the basis that it provided for consistency and certainty. For example, the Health and Care Professions Council felt that the legal framework should be prescriptive about the size of Councils and equal lay and registrant membership. It thought this was necessary in order to maintain

⁷ Of the 192 submissions which were received, 63 expressed a view on this question: 14 supported option one, 13 supported option two, 31 supported option three, whilst 5 held equivocal positions.

public confidence and “avoid any possible perception that regulators make decisions in the interests of the professions as opposed to upholding the public interest”. This view was shared by the British Association for Counselling and Psychotherapy, which argued that “Councils should decide the ends not the means and hold the executive to account and ensure that public protection is central to all decisions”.

- 4.55 Some also felt that the use of regulations would allow for the future proofing of the legal framework. For example, the Institute of Medical Illustrators argued that regulations give “a certain flexibility for unforeseen circumstances whilst ensuring that the size and composition is not unduly rigid”.
- 4.56 Most who opposed this option were concerned to limit the powers of Government. For example, the British Dental Association argued that if this option was adopted, and Government were given powers to approve constitution orders, then “the executive would have complete control over the regulator”.

Option three: general powers for the regulators

- 4.57 Many supported this option because they felt it would give the regulators maximum flexibility. For example, Coventry and Warwickshire Partnership Trust argued that the variation in size of the different regulated professions makes it difficult to have a consistent Council size. UNISON also argued that “it is important that boards do take a proportionate account of the numbers of individuals they regulate”. The General Osteopathic Council felt that this option recognised the differences between the size and turnover in the regulators, as well as being the “least resource intensive” for the Government.
- 4.58 Some consultees – particularly professional bodies – favoured this option because they felt it could secure an increased number of registrant members. For example, the British Association of Music Therapy argued that it is important that individual professions are adequately represented at Council level in the context of a multi-professional regulator such as the Health and Care Professions Council. On the other side, the British Association of Dental Nurses did not agree with this option because it would lead to the General Dental Council “continuing to sideline its members and to reflect primarily the views and interests of dentists”.
- 4.59 Most who opposed this option were concerned about giving the regulators too much discretion on such important matters. The Professional Standards Authority argued that it “provides too much latitude and would create instability and distraction” and “it may also provoke ongoing Government involvement in the regulators”.

Other comments

- 4.60 Some consultees favoured a combination of the options set out above. For example, the General Medical Council argued that the proportion of lay and registrant members on the Council is a matter of overriding public interest that should be specified in statute (option one). However, it felt that the Council size should be left to regulations (option three) because “it is not a matter of such overriding public interest as to need to be fixed in statute” and “perceptions of the ideal size may, in any event, change over time”. Furthermore, it argued that the

issue of size relates to the nature of the regulator (rather than how it regulates) and therefore should not be left to the Councils themselves to determine but should be specified by Government in regulations. The General Optical Council argued that the size should be left to the regulators to determine (option two), but that “the principle of an equal split between lay and registrant members ... is important enough to warrant inclusion in the statute” (option one).

4.61 An alternative approach was suggested by the Centre for the Advancement of Interprofessional Education. It argued that the Professional Standards Authority should set the Councils size and consider the mix of lay, profession-specific and other professional members.

4.62 The Department of Health argued that the Privy Council should have an order-making power to set the parameters within which the regulators may constitute their Councils “for example by setting maximum and minimum number of council members, the proportion of lay and registrant members”.

4.63 Similarly, the Scottish Government supported an approach whereby:

The Government and, where applicable, the Scottish Government, should set parameters within which the regulators can establish their Councils, including the proportion of lay/registrant members.

4.64 Some responses argued for greater professional representation on the Councils. For example, the Royal Pharmaceutical Society of Great Britain stated that:

Professional input at a strategic level is essential. Members of a profession have a unique body of knowledge and expertise, and, as professionals, will act in the best interest of their patients.

4.65 Many representative bodies argued that the moves by Government to reduce the size of Councils would mean that the ability of the regulators to secure the expertise and support from the regulated professions would be reduced. Concerns were also raised about the ability of a small Council to be representative of all four countries of the UK.

4.66 Some responses queried the position of the Council chair in our proposed scheme. The General Optical Council felt that – as well as establishing an equal split between lay and registrant members – the statute should make allowance “for an additional lay chair”. The General Social Care Council argued that the chair of each Council should be lay “in order to maintain the independence of the regulator and to enhance public confidence in the profession”.

Provisional Proposal 4-7: The statute should define a lay member of the Council as any person who is not and has not been entered in the register of that particular regulatory body, and a registrant member as any person who is entered in the register of that particular regulatory body.

4.67 A large majority agreed with this proposal.⁸

⁸ Of the 192 submissions which were received, 39 expressed a view on this proposal: 30 agreed, 7 disagreed, whilst 2 held equivocal positions.

4.68 However, several consultees suggested a more restrictive definition of a lay member. For example, the General Medical Council pointed out that our proposed definition of a lay member could include doctors who hold professional qualifications but who had not been granted registration. Instead, it proposed defining lay member as:

someone who is not and has never been entered in the register of that particular regulatory body and *does not hold a qualification which would render that person eligible to be entered in the register.*⁹

4.69 The Pharmaceutical Society of Northern Ireland pointed out that, under our proposed definition of a lay member, a pharmacist previously registered with either the Pharmaceutical Society of Ireland or the General Pharmaceutical Council could become a lay member of its Council. It therefore proposed that those eligible to join the relevant register should be precluded from being a lay member.

4.70 The Health and Care Professions Council argued that the definition of a lay member should exclude any person who was included on the register of a predecessor organisation. The General Social Care Council also argued that the definition should exclude people who have been practising the profession during a period where there was no registration requirement. It pointed out that it considers social workers who were in practise before the introduction of statutory regulation in 2005 to be registrant members.

4.71 The Health and Care Professions Council also argued that the definition of a lay member should exclude any professional who is registered with another health or social care regulatory body. It felt that a more stringent definition would reflect “the reasonable expectations that most members of the public would have of a lay member”. The Guild of Healthcare Pharmacists also supported that approach. The Patients Association also argued that the definition of lay member should be limited to those who have never been registered with any health related regulator. It stated that:

For example, nurses and doctors will often work in very close quarters, sharing working environments, stresses and concerns. It would seem inappropriate for a nurse to be described as a “lay member” at the General Medical Council when they in all likelihood have been working amongst doctors as a healthcare professional throughout their entire professional career.

4.72 However, the General Osteopathic Council supported the definition of lay incorporating other health professionals because “for a small, developing profession their input – particularly in areas such as education and training – can be extremely valuable”. Similarly, the General Optical Council considered that a blanket exclusion for all health professions would be too broad.

⁹ Emphasis added.

4.73 The General Optical Council also pointed out that its definition of lay members excludes current and former directors of registered bodies corporate and anyone holding a qualification that would make them eligible for registration.

4.74 Some consultees argued for a broader definition of a registrant member. For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland felt the definition should include those eligible to be on the register – including those who have withdrawn as matter of personal choice or having moved away from active practice. Nevertheless, the Forum warned that a Council populated by non-practising professionals should be avoided.

4.75 Similarly, the Professional Standards Authority argued that the definition of a registrant member should be expanded to include “those individuals who have been but are not currently registered”. It felt that:

This provides clarity for all stakeholders and may be of practical benefit to those regulators where there is a relatively small pool of registrants to appoint from (subject to meeting the criteria for a good appointment and they had not lapsed because of serious fitness to practise concerns).

4.76 However, the Scottish Government suggested that “a registrant member should be registered with that body during the period of their appointment to the Council”.

4.77 The Nursing and Midwifery Council queried whether voluntary registrants should qualify as registrant members or lay members. An individual consultee (James Kellock) also queried whether a registrant of a foreign professional body practising in the same area is eligible to be appointed as a lay member.

Question 4-8: Should Council members be prohibited from concurrent membership of another Council?

4.78 A slim majority felt that Council members should be prohibited from concurrent membership of another Council.¹⁰

4.79 The Health and Care Professions Council argued that concurrent Council membership reflects negatively on the image of the regulators. It said:

We consider that concurrent council membership concentrates the power of regulators in the hands of a few and could also lead to potential conflicts of interest in relation to certain policies that may be adopted by councils. We have never experienced difficulties in attracting a high calibre of Council members such that it would precipitate concurrent membership.

4.80 The Scottish Government stated:

¹⁰ Of the 192 submissions which were received, 39 expressed a view on this question: 20 said that concurrent membership should be prohibited, 16 said that it should not, whilst 3 held equivocal positions.

In the interests of transparency and fairness, ensuring faith, trust and confidence in the professions and the regulatory process, and to avoid the perception of bias we recommend that Council members should be prohibited from concurrent membership of another Council. This would also reduce the potential for any “cross-contamination” and recognises that the relevant expertise can be found in a range of individuals rather than vested only in a small number. This would also afford considerably more transparency.

4.81 The Pharmaceutical Society of Northern Ireland stated:

Whilst the potential for experienced and concurrent members of other regulatory Councils to bring knowledge to other Councils is recognised, there is concern that such individuals will be disproportionately successful in securing appointments to the detriment of other individuals. The risk of limiting the pool of potential candidates brings with it the loss of fresh thinking and innovation which could be gained from other sectors.

4.82 The Medical Protection Society agreed that concurrent membership would have the effect of “limiting the positions open to new people who may bring fresh views and insight”. The British Association for Counselling and Psychotherapy felt that a prohibition was necessary to prevent the development of a “pseudo profession” and subsequent loss of the “distance and alternative view” brought by lay members. The British Medical Association did not accept that an individual would be able to devote sufficient time to undertake each role effectively.

4.83 The Patients Association argued that cross membership reflected poorly on the regulators. It felt that:

The “old school tie” image of self regulation does nothing to improve public confidence in their operation, and every effort should be made to ensure that not only is this not the case, but that there is not even the possibility of such a perception.

4.84 The McTimoney Chiropractic Association agreed “that ‘the old boys’ network’ undermines confidence both by registrants and the public”,

4.85 The Professional Standards Authority anticipated that there will be a smaller total number of board places in the future and that a prohibition on concurrent membership would allow “an individual to focus on a single role and avoids any conflicts of interest arising”. It suggested that conflicts of interest “may be more frequent and consequential if there are additional instances and opportunity for joint working and collaboration”.

4.86 However, the General Medical Council felt there were advantages in concurrent membership, such as facilitating “shared learning and experience, the cross-fertilisation of ideas and harmonisation of regulatory approaches”. The Scottish Social Services Council agreed that the sharing of ideas was a positive benefit of concurrent membership.

- 4.87 The Department of Health expressed concerns “about the capacity of an individual to serve on more than one regulatory body” but felt there was no reason for a prohibition. It thought that:

In practice any appointing body would give due consideration to the capacity of the individual to take on multiple roles and of any potential conflicts of interest which may arise.

- 4.88 The Nursing and Midwifery Council also felt that rather than prohibiting concurrent membership, the key issue is to ensure that each Council member “has the right skill set and the ability to give the necessary time commitment to enable them to carry out their duties and make an effective contribution”.

- 4.89 The Medical Defence Union argued that concurrent membership should be allowed “in the interests of fostering consistency and co-operation among regulators and sharing of best practice”. However, this would need to be “subject to approval from the ‘first’ regulator” and undertaken in circumstances “where membership of the ‘second’ regulator did not prevent the Council member from properly fulfilling his or her duties in respect of the ‘first’”. The Medical and Dental Defence Union of Scotland argued that a prohibition would reduce the pool of qualified participants in professional regulation and governance.

- 4.90 Some consultees argued that Council members should be prohibited from being a member of more than two Councils at the same time. Coventry and Warwickshire Partnership Trust felt this would “encourage exchange of ideas between councils, but stop ‘career’ committee members from holding multiple posts”. This approach was also supported by the British Psychological Society.

- 4.91 The General Osteopathic Council argued that, while there should be no absolute prohibition:

It is important that regulators are clear why it is in their interests to appoint such members, rather than expand the pool of external expertise supporting the regulators.

- 4.92 The Council also felt that the regulators should draw the net widely when seeking Council members. While recognising the importance of being able to draw on expertise and experience from other regulators, it argued that the selection processes “must not overly favour those with pre-existing knowledge and experience of health care professional regulation”.

Provisional Proposal 4-9: The regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees if they wish to do so.

- 4.93 An overwhelming majority supported this proposal.¹¹ For example, the General Chiropractic Council agreed that the decision “whether to have committees and how they should be composed” are matters for the regulator. Similarly, the British Chiropractic Association and Allied Health Professions Federation welcomed the

¹¹ Of the 192 submissions which were received, 43 expressed a view on this proposal: 40 agreed, whilst 3 expressed equivocal positions.

proposal. The Academy of Medical Royal Colleges supported the proposal “as it allows for flexibility”.

- 4.94 Several consultees supported the proposal, but stressed that there would need to be some external scrutiny. For example, NHS Greater Glasgow and Clyde thought that any governance arrangements would need to be “open to scrutiny and involve stakeholder involvement in evaluating function/transparency”.
- 4.95 The General Optical Council argued that if regulators are to be required to reduce the size of their Councils, they should “be given the ability to change their other governance arrangements as necessary, to make best use of their members and committees”.
- 4.96 The General Medical Council agreed with this proposal but felt the governance arrangements for committees did not need to be in rules but could be achieved through standing orders. It also argued that detailed rules should not be required for “ad-hoc working groups and other similar fora that may need to be established from time to time”.
- 4.97 Some consultees representing midwives expressed concern that the proposal could lead to the abolition of the Midwifery Committee by the Nursing and Midwifery Council.
- 4.98 The Scottish Government agreed with the proposal, however it also stated that:

An exception to this would be in relation to groups such as midwives who currently have a separate committee established under the Nursing and Midwifery Council. We would propose that a clause is added in the new statute which reflects the requirement for regulators to consult and seek Government/Department of Health and, where relevant, devolved administration approval where the establishment or removal of committees would impact significantly on such professions.

- 4.99 A small number of responses supported a uniform system of statutory committees across all the regulators. For instance, the Optical Confederation supported preserving certain core committees, in any new legislation, namely the Fitness to Practise Committee, Investigation Committee and Registration Appeals Committee.

Provisional Proposal 4-10: The regulators should be able to make rules for committees or any other internal groups it establishes, including their size and membership.

- 4.100 All the consultees who responded to this proposal agreed that regulators should have the power to make rules for committees or any other internal groups.¹²
- 4.101 NHS Greater Glasgow and Clyde agreed, subject to:

¹² Of the 192 submissions which were received, 33 expressed a view on this proposal: all agreed.

the overriding caveat that governance arrangements must clearly and unambiguously account for regulatory function, be open to scrutiny and involve stakeholder involvement in evaluating function/transparency.

- 4.102 The Chartered Society of Physiotherapy felt that regulators should “subject their structures to periodic review to ensure that they remain fit for purpose”.

Provisional Proposal 4-11: Each Council should be given powers to delegate any of its functions to any Council member, officer or internal body. Any delegations must be recorded in publicly available scheme of delegation. There should continue to be a prohibition on delegating any power to make rules.

- 4.103 The vast majority agreed with our proposed powers of delegation.¹³
- 4.104 The General Osteopathic Council supported the proposal. However, it felt that there was potential for “conflict and loss of effective accountability” if the Councils delegate their functions to individuals outside of the line management structure, rather than to the Chief Executive to delegate to others “under normal managerial arrangements”.
- 4.105 The Professional Standards Authority considered that this proposal was too broad and argued it would not be appropriate for the Council to delegate, in the interests of “good decision making”. For example, “it would be inappropriate for Council to delegate to a Council member any adjudication on fitness to practise”. The General Social Care Council shared this view.

¹³ Of the 192 submissions which were received, 37 expressed a view on this proposal: 36 agreed, whilst 1 held an equivocal position.