

## **PART 6**

# **EDUCATION, CONDUCT AND PRACTICE**

**Question 6-1: Should our proposals go further in encouraging a more streamlined and coordinated approach to regulation in the areas of education, conduct and practice? If so, how could this be achieved?**

- 6.1 A large majority argued that our proposals should go further in encouraging a more streamlined and coordinated approach.<sup>1</sup> For example, UNISON said that it “would strongly welcome greater collaboration across regulators”.
- 6.2 The General Medical Council acknowledged that greater joint working between regulators can “add value to the regulatory process” and ensure “better sharing of intelligence, better co-ordination of activity and reduced regulatory burden”.
- 6.3 Several consultees pointed to the problems caused by a lack of cooperation and coordination. The Professional Standards Authority argued that:
- the combined, and often cumulative, activity of the regulators in these areas demonstrates considerable duplication, which we are aware causes puzzlement and occasionally frustration at the apparent inconsistencies in delivery of very similar regulatory functions.
- 6.4 The Medical Defence Union pointed out that “in some specialties clinicians take out dual registration with the General Dental Council and the General Medical Council”. It warned that problems can arise if there is no joint working between these regulators. It provided an example of when the General Dental Council issued rules requiring the dual registration of maxillo-facial surgeons, which resulted in the “potential for prosecution of medical doctors in training (anaesthetists as well as maxillo-facial surgeons) and in theory their trainers”.
- 6.5 An individual consultee (Lucy Reid) felt there was a lack of a coordination between the regulators and the Performers’ List maintained by Primary Care Trusts; for example, if an “inexperienced practitioner” applies to a Performers’ List, the Trust can apply conditions to allow them to practise, however “this minimum standard is not currently set by the regulators appropriately, partly as a result of overseas training and qualifications”.
- 6.6 Several consultees argued that the statute should promote joint working. For example, the Centre for the Advancement of Interprofessional Education felt that each of the regulators should “be required explicitly to promote interprofessional collaboration” and that “each committee, board and panel within a regulatory body [should include] a proportion of members from other professions”.

<sup>1</sup> Of the 192 submissions which were received, 47 expressed a view on this question: 37 said that our proposals should go further, whilst 10 said they should not.

- 6.7 However, some consultees did not think that our proposals needed to go further. For example, Optometry Scotland thought that the “current arrangements are satisfactory” as they allow “a reasonable level of flexibility”. The Medical Protection Society agreed that the “current level of oversight of the regulators is appropriate in the educational context”.
- 6.8 The General Optical Council and General Dental Council were willing to consider ways of streamlining the current system, but stressed that regulators must retain the flexibility to regulate their sectors appropriately.
- 6.9 The Department of Health emphasised the importance of “ensuring compliance by the regulatory bodies with EU legislation, in particular EU Directive 2005/36/EC on the recognition of qualifications”. It suggested that all rule-making powers should specify this.
- 6.10 The Department also supported “a broad power for the regulators to work together (and with other bodies) on education and training matters” in order to support a “more coherent approach towards engaging with education providers” for example, “in relation to the various data returns they have to provide to the different regulators”.
- 6.11 The Scottish Government called for the establishment of a new body to ensure a more coordinated and streamlined approach:

The new statute could provide further clarity and consistency by co-ordinating their activities through one central body with representation from individual regulators as required (ie a ‘hub and spoke’ model). This would provide greater consistency in standards and a more co-ordinated approach to quality assurance and inspections, and provide opportunities for shared learning and decision-making including, for example, in relation to multi-disciplinary/multi-professional education and training. Any decision to reduce or withdraw involvement in any of these areas would be subject to the agreement of all the regulators and the overarching duty to protect the public and maintain confidence in the professions.

- 6.12 The Scottish Government also wanted to explore whether the new statute should ensure “a combined code of conduct, performance and ethics that would apply across all the regulators” and “whether similar consistency could be provided in the approach to continuous professional development”.
- 6.13 The Department of Health, Social Services and Public Safety for Northern Ireland pointed to the need to develop:

a more corporate approach to regulation that would involve, for example, employers and educational providers. Regulation is not the exclusive province of a regulator – it needs to embrace other stakeholders. Also the development of core principles across all regulators would establish some consistency.

### ***Education***

- 6.14 Many commented specifically on education issues. The Professional Standards Authority felt that greater cooperation will demand certain consistencies to be established “in terms of quality assurance of education [such as] the subject of the approval – institution or programme or environment or course”. The Committee of Postgraduate Dental Deans and Directors expressed concern that unlike the General Medical Council, the General Dental Council does not quality assure foundation training and education/training throughout a registrant’s career.
- 6.15 The Chartered Society of Physiotherapy argued that the Professional Standards Authority had a key role in ensuring a “light touch” and “outcomes based” approach to the regulation of education and training. The General Medical Council felt that because “education is a complex field with many interdependencies” the regulators should have “statutory levers (for example, to require information, undertake inspections and withdraw recognition of training)” in order to “support the delivery of their functions”.
- 6.16 Several consultees argued the statute should ensure the involvement of professional bodies in education and training. For example, the British Society of Hearing Aid Audiologists argued that the regulators should be required to “enter into partnerships with professional bodies” in undertaking the approval of pre-registration and post-registration courses. However, an individual consultee (Jane C Hern) cautioned that where education providers and regulators do work together, the latter should be aware of the “need to minimise the burdens on universities etc, which may have to satisfy the differing requirements of a number of regulators”.
- 6.17 However, the Royal College of Radiologists argued for greater demarcation of responsibilities and that doctors in postgraduate training should be “primarily the responsibility of the postgraduate deaneries” and “doctors who have completed training should be in the first instance the responsibility of the responsible officer”.

### ***Conduct and practice***

- 6.18 In relation to conduct and practice, the Nursing and Midwifery Council commented that our proposals could go further by providing for:
- a generic core code of conduct for all health professionals, covering issues such as the centrality of the patient interest, involving patients in decisions, confidentiality, keeping up to date and raising concerns all at an appropriately high level.
- 6.19 The Royal College of Radiologists argued for:
- a uniform standard of care whoever is providing it, so lower standards of care for a procedure or investigation should not be acceptable when it is routinely provided by a nurse, for example rather than by a doctor. A uniform standard for that activity should be upheld, preferably with advice, and preferably consensus from organisations like Royal Colleges or professional organisations. If the same standard cannot be achieved then the activity should be restricted to those who can attain that standard.

6.20 However, some consultees urged caution in developing a coordinated and streamlined approach. An individual consultee (Jacqueline A. Wier) felt that “specific issues that relate to individual professions need specific knowledge and expertise” and “it is important that these are not lost in the drive for improved efficiency”. The Professional Forum of the Pharmaceutical Society of Northern Ireland supported the principle of a coordinated approach to education but stated “this cannot become a one size fits all dogma”.

6.21 The Royal Pharmaceutical Society of Great Britain argued that:

Multidisciplinary working is only successful if based on sound individual professional development. Each profession must bring its own expertise to the team and education, conduct and practice standards can have overarching elements, such as confidentiality, but must also be specifically developed for the individual profession.

6.22 The General Osteopathic Council argued that while a multitude of organisations are involved in education, conduct and practice, this position is not consistent across all professions and in osteopathy there is no other body than the General Osteopathic Council that “has a remit for these issues”. It further argued that:

Given the diversity of the professions under regulation, the history of their development and the variety of institutions involved, it is not obvious that this statute would be the place to seek to introduce a more streamlined approach beyond the general duty of cooperation ... It is also important to ensure that accountability for the quality of clinical education which involves direct patient care is clear. This must remain with the regulator.

**Provisional Proposal 6-2: The statute should require the regulators to make rules on:**

- (1) which qualifications are approved qualifications for the purposes of pre-registration and post-registration qualifications;**
- (2) the approval of education institutions, courses, programmes and/or environments leading to an award of approved qualifications and the withdrawal of approval;**
- (3) rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institution, course or programme;**
- (4) the quality assurance, monitoring and review of institutions, courses, programmes and/or environments; and**
- (5) the appointment of visitors and establishment of a system of inspection of all relevant education institutions.**

6.23 All of those who expressed a view agreed with the proposal.<sup>2</sup> For example, the National Clinical Assessment Service was in favour of the regulators having rule-making powers in this area, as it would “support the improvement of education standards”. Many consultees provided comments on the specific elements of this proposal.

6.24 The Department of Health felt that the regulators should have a power to approve post-registration courses, rather than an obligation to do so, as some use continuing professional development for this purpose.

6.25 The Association of Clinical Biochemistry argued that the statute should enable the “recognition of prior experience and education other than formal approved education schemes and qualifications” (as currently provided for in the Clinical Scientists part of the Health and Care Professions Council’s register). It argued this provides a “career route mechanism for experienced scientists from academia, industry and elsewhere”. Similarly, the General Dental Council suggested the wording of the statute should be “sufficiently wide to encompass a requirement for vocational training as well as academic training”.

6.26 Several responses noted the importance of securing effective practice settings. NHS Education for Scotland pointed out that:

Whilst the majority of the preparation of health care professionals is within higher education these programmes are delivered in partnership with clinical practice areas predominately but not exclusively the NHS.

6.27 The General Optical Council argued that “not all regulators have an existing internal appeals process regarding decisions on approval of training providers” and any duty to introduce this process might impose additional financial burdens.

<sup>2</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: all agreed.

6.28 The Professional Standards Authority argued that the new legal framework “should be more flexible around quality assurance” since:

It may not be necessary for regulators to quality assure programmes themselves to confirm that those individuals completing courses are fit to join the register, especially if other agencies share the regulator’s interest in the course. The statute may not need to require all regulators to make rules around quality assurance, providing they have provision for monitoring and reviewing institutions.

6.29 It also argued that the statute should define who can act as a visitor, the options available for an appeal and the purpose of approval and monitoring reviews.

6.30 The Nursing and Midwifery Council suggested that the appointment of visitors should be “a permissive power and left to the discretion of the regulators” because “their use might be just one approach to assuring the quality of provision, there may be others”. The General Dental Council also argued that “inspection is not the only model of quality assurance” and the statute should refer to “mechanisms for quality assurance of education, which may include the appointment of visitors and the establishment of a system of inspection”.

6.31 The Scottish Government supported our proposal but again felt that it may be appropriate to explore further a centralised “hub and spoke” approach to the appointment of visitors. It also argued that visiting schemes should be extended to include practice placements and the regulators should be able to choose from “an agreed suite of sanctions (such as formal warnings and conditions) when addressing quality assurance problems”.

6.32 The General Osteopathic Council suggested the following additional powers:

- (1) to set and enforce conditions and require action to remediate (something similar to Ofsted’s “special measures”);
- (2) to charge for inspection activity – particularly because most osteopathic education is delivered in the independent sector and not in the traditional university sector; and
- (3) to restrict the extent of the approval to education and training delivered in the UK should the regulator so wish.

6.33 The Health and Care Professions Council questioned whether the regulators should be given powers to use “special measures for struggling institutions” and argued that “the use of formal warnings and conditions for approval should be sufficient”. It also argued that:

The regulators should not be able to introduce “excellence schemes”. The primary purpose of regulation is public protection and not the promotion or development of the professions. The suggestion that the regulators might operate such schemes appears to stray into the role of professional bodies in developing, as opposed to regulating, the professions.

- 6.34 Some consultees pointed to the key role of professional bodies in education and training. For example, the Academy of Medical Royal Colleges argued that while the regulators should set standards for education:

it is for professional bodies like Royal Colleges (postgraduate) and universities (undergraduate) to determine the content and standards of curricula, assessments and qualifications ... Royal Colleges and professional bodies, as independent experts, are in an ideal position to contribute to quality assurance through playing a role in visiting and inspection arrangements.

- 6.35 The Osteopathic Alliance warned that “the more that the regulator is involved in postgraduate education the more this could stifle development, innovation and on-going patient care”. The Royal College of Physicians of Edinburgh felt that specialist Royal Colleges “require resourcing to support the regulator in this way”.
- 6.36 The Department of Health argued that the regulators should be required to comply with EU requirements in making rules. Similarly, the Scottish Government argued that the statute should make explicit reference to compliance with EU legislation.

**Provisional Proposal 6-3: The statute should require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and publish information on any decisions regarding approvals.**

- 6.37 All those who expressed a view agreed that the statute should require the regulators to publish a list of approved institutions and/or courses and programmes, and the publication of decisions regarding approvals.<sup>3</sup> For example, the Nightingale Collaboration argued that:

It is in the interest of students and prospective students that full information about training establishments is published so they can make an informed decision about their choice of training provider. This should include full curriculum details, accreditation details, inspection reports, remedial actions required by the regulator, etc.

- 6.38 The British Pharmaceutical Students' Association argued that this proposal would “act to drive up the quality of Master of Pharmacy courses within an increasingly competitive higher education market”. NHS Greater Glasgow and Clyde agreed with the proposal on the basis that it would “reinforce public confidence and engagement”.
- 6.39 Some suggested additions to the duty. The Professional Standards Authority felt that the regulators should be required to publish:

all decisions around approvals of courses, programmes and institutions, as well as the decision-making process they adopt. This is useful information for sharing good practice and it is helpful for

<sup>3</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: all agreed.

students, commissioners and other agencies with an interest in the quality of education delivery

- 6.40 NHS Education for Scotland felt that the duty should include “practice placement areas”. The Department of Health agreed, and the Scottish Government also felt that the duty should be extended to include “establishing and maintaining an approved list of practice placements publication”. Similarly, the Department of Health, Social Services and Public Safety for Northern Ireland suggested that the publication requirements “should also specify approval of placements”.
- 6.41 The Professional Forum of the Pharmaceutical Society of Northern Ireland stated that “all accreditation reports produced by the regulators should be made publicly available”.

**Provisional Proposal 6-4: The statute should require education institutions to pass on to the regulator in question information about student fitness to practise sanctions.**

- 6.42 A large majority agreed that education institutions should be required to pass on information about student fitness to practise sanctions.<sup>4</sup> For example, the Professional Standards Authority argued that:

It would benefit public protection if relevant information about student fitness to practise was available when a decision is taken about registration. Admission to the register should not neglect any information which may have a bearing upon an assessment of fitness to practise.

- 6.43 The National Clinical Assessment Service supported the proposal because an “education institute has a duty to act in the patient public interest”. The British Pharmaceutical Students' Association argued that such a requirement would “remove the need for a student register”.
- 6.44 Several consultees suggested that the proposal reflected existing practice. The General Chiropractic Council pointed out that a similar requirement is stated in its guidance. The Royal College of Physicians of Edinburgh argued that:

Medical directors and undergraduate deans have a professional responsibility to advise the regulator of fitness to practice sanctions at local level. It may be helpful to add an organisational responsibility.

- 6.45 The Pharmaceutical Society of Northern Ireland also argued that:

Educational institutions should inform regulators of student fitness to practice issues, which are above certain established and published thresholds as is the case with the universities we accredit ... However it is also incumbent on the universities to manage misconduct within the university disciplinary code, and to not see this as an abdication of their responsibility.

<sup>4</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 36 agreed, 5 disagreed, whilst 3 held equivocal positions.



- 6.46 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group welcomed the proposal, whose implementation the Group thought would promote a “move away from needing student indexing”.
- 6.47 Some suggested amendments to the duty. Coventry and Warwickshire Partnership Trust argued that this information should be shared with other educational establishments. The General Medical Council suggested that the duty “should apply equally to service providers (such as NHS Trusts) which provide regulated education and training”.
- 6.48 The Scottish Government argued that the duty to share information about student fitness to practise sanctions should include “any other matters that question student conduct, character or general fitness to practise”.
- 6.49 However, some pointed to potential difficulties with the proposal. For example, the Nursing and Midwifery Council felt that:

In order to manage the information, it would be necessary to maintain some form of register of nursing and midwifery students, something that we have been discouraged from doing as it is not seen as part of our core function. We would suggest that the requirement should be for information to be provided “on request”.

- 6.50 It also argued that clarity is needed in cases where fitness to practise concerns are raised about students who are already registrants but are “undertaking a programme for another registrable qualification”.
- 6.51 The General Optical Council suggested that the regulators are given powers to request this information, since there are differences among the regulators “in respect of how student fitness to practise is managed, which a more flexible approach in the statute might more easily accommodate”.
- 6.52 The Royal College of Nursing felt that greater clarity is needed on what the regulators should do with this information, “for example – is the regulator expected to create what amounts to a ‘blacklist’?” It also felt that the requirement to share information about all sanctions was “too stringent”, for example this would include students subject to warnings.
- 6.53 A small number opposed this proposal outright. The Health and Care Professions Council argued that a duty was “unnecessary and disproportionate” since:

Our standards of education and training and approval process ensure that education providers have robust procedures in place to deal with concerns about the conduct of students. Where an education provider has “disciplined” a student but taken action short of removal from the programme, and that student has subsequently passed their programme, and therefore met the regulator’s standards, it is highly unlikely that the regulator would be justified in making the serious decision not to register them. Our concern therefore is that regulators would routinely receive information on which they would be highly unlikely to take any meaningful action.

6.54 It was therefore argued that this should be a discretionary matter that the regulator may wish to address in rules, standards or guidance.

6.55 The Optometry Course Team at the University of Ulster felt that:

whilst this would be appropriate for some fitness to practise matters, for more minor issues it may be viewed as unnecessarily punitive and may inadvertently result in institutions being reluctant to impose a minor sanction if they feel it is going to inappropriately result in a referral to the regulator. For example educational institutions, under their current statutes and ordinances, regularly deal with students who have committed minor indiscretions, often as a result of youthful immaturity. Whilst for the maintenance of the educational establishment's reputation or to encourage the personal development of the student some consequences may be necessary, for the regulator to have to be informed would often be disproportionate. Obviously matters of a more severe nature, resulting in a criminal conviction or a severe sanction should be referred to the regulatory body as these may impede the possibility of future registration.

6.56 The Registration Council for Clinical Physiologists also generally opposed the proposal, but accepted that there "may be exceptions to this if there are serious issues that would result in a student not being fit to practise".

6.57 The Association of Clinical Biochemistry argued that "the primary concern should be that the student meets the requirements for registration at the point they present themselves for assessment" and disagreed that "deficiencies which were resolved during pre-registration education should disproportionately be held against an applicant". The Council of Deans of Health felt that such a "blanket requirement" would undermine the aim of "right touch" regulation and a "disproportionate response to the perceived level of risk posed".

6.58 The Society and College of Radiographers' opposition to the proposal was linked to its lack of support for student registers more generally. It was argued that "in the absence of a register, the regulator should have no use for information on sanctions against students".

**Question 6-5: Should the powers of the regulators extend to matters such as a national assessment of students?**

6.59 A majority felt that regulators should not have powers to introduce a national assessment of students.<sup>5</sup> For example, the Welsh Government did not support giving the regulators powers to introduce national assessments "as it would lead to examinations becoming Anglocentric". The Department of Health, Social Services and Public Safety for Northern Ireland also disagreed with the proposal.

6.60 The Dental Schools Council argued:

<sup>5</sup> Of the 192 submissions which were received, 54 expressed a view on this question: 12 said that the regulators should have such powers, 37 disagreed, whilst 5 held equivocal positions.

Undergraduate dental education is more than just a means of achieving registration; it aims to provide dental students with opportunities to demonstrate excellence in a range of clinical and academic domains as well as competence in those core skills and competencies required for registration. National assessment could not demonstrate the breadth of these skills and competencies in the same way as the overall programme of assessments delivered by dental schools.

6.61 The British Dental Association also pointed out that “dental schools have differing methods of assessment, influenced by a range of factors” and that a “standard assessment would prove invalid across the sector”. The Association felt that the “regulator is not a recognised source of expertise in education; this resides within Universities”. The Guild of Healthcare Pharmacists agreed that assessment is the “domain of education and training providers”.

6.62 The Medical Defence Union argued that a national assessment of students would add little value “over and above the assessments that regulators currently make of applicants at [registration]” and would not ensure patient protection “when the information available relates generally only to their education and training” and “there is so little information available at this early stage in their career”. NHS Education for Scotland also argued that national assessment was unnecessary given that “the regulator provides a code of conduct and standards for entry to the register” and would be “extremely difficult and expensive and questionable in respect to risk”.

6.63 The British Medical Association felt that:

A national exam would do nothing further to ensure that medical graduates are suitably prepared for entry into the medical workforce, but would instead stifle the diversity of medical education in the UK - negatively impacting on the range of skills and strengths of our workforce ... There is a risk that a national exam from a regulatory body would supersede the existing finals examinations, which have been shown to be fair, transparent and rigorous, and homogenise the curriculum of undergraduate medical school to fit with a single, national idea of what makes a good doctor rather than allowing the freedom for schools to work with their graduates in a positive way to develop their own strengths.

6.64 The Patients Association felt that national assessment could become:

a box ticking exercise, ensuring that graduates meet the minimum requirements necessary and leaving it at that rather than seeking to provide a level of excellence and deeper understanding in students of what is expected of them when they qualify.

6.65 An individual consultee (Stephen King) queried whether the proposed extension of the regulators’ powers was “really necessary”, or whether it would “mean duplication of the regulatory body taking on the role of a quasi examination body”. The risk of duplication was also a concern of the British Psychological Society.

6.66 The Council of Deans of Health felt that:

In setting robust standards for education and training, it should be unnecessary for regulators to take part in national assessments of students for the purposes of public protection.

6.67 The Professional Standards Authority argued there is only a case for a national assessment “in the absence of other quality assurance mechanisms”.

6.68 However, some were in favour of giving regulators powers in this area. For example, the General Medical Council argued that:

Regulators should be able to introduce national assessment of students and trainees, auditing of data which highlights individual progression and other such approaches where they consider they offer effective and proportionate means of fulfilling their paramount duty.

6.69 Coventry and Warwickshire Partnership Trust argued that national assessment “will help to reduce the current inconsistencies in the approach of education providers to the assessment of students, especially at undergraduate level”. The Royal College of Physicians of Edinburgh suggested that “consistency of standards on graduation from medical school has been a long standing issue and should be tackled by the regulator”.

6.70 The British Pharmacological Society argued that national assessments can be preferable to reviewing the education process in individual institutions because:

- (1) those reviews are necessarily brief;
- (2) the evidence presented may be selected;
- (3) it can never be certain that even good educational opportunity actually translate into clinical competency;
- (4) in many areas of undergraduate education, such as prescribing, it is not yet known what constitutes the optimal approach to learning; and
- (5) when individual institutions choose their own methods of assessment the result is a highly variable approach.

6.71 The Society therefore supported national assessments which are restricted to:

specific competency in critical high risk areas for which a basic minimal standard is highly desirable and in the interests of patient safety. To this end we are working with the Medical Schools Council to develop the Prescribing Skills Assessment (PSA). The PSA is designed to assess the prescribing competencies expected of a foundation doctor, as stated by the General Medical Council. Prescribing is a core component of the work of a foundation doctor who is expected to write and review prescriptions from their first day of practice. There is clear evidence from a General Medical Council study that there are issues around prescribing competencies with 9% of hospital prescriptions containing errors. Therefore the PSA is a

means of ensuring that core prescribing competencies are achieved by all new graduates prior to starting work in hospitals.

- 6.72 The General Pharmaceutical Council pointed out that it currently holds a national assessment for pre-registration pharmacy students and the statute should enable (but not require) this to continue and develop. It stated:

We believe that this is a helpful tool that contributes to ensuring only those students who are competent to practise are entered onto the register. However, we recognise that this registration assessment, introduced in 1993, reflects the unique circumstances of the pharmacy education model including the way in which pre-registration is managed and quality assured across Great Britain.

- 6.73 The Royal Pharmaceutical Society of Great Britain pointed out that this system is in addition to “a broad indicative syllabus” issued by the regulator for the undergraduate degree, and Schools of Pharmacy are accredited against standards to ensure the quality of the degree.

- 6.74 A number of regulators, including the General Osteopathic Council, General Dental Council and General Optical Council, thought that the regulators should be given a permissive power in this area. This was supported by the Department of Health, which felt that “it may be helpful for the regulators to have powers (rather than obligations) to set or ask others to set national assessments of students”.

**Question 6-6: Should the regulators be given powers over the selection of those entering education?**

- 6.75 A large majority argued that the regulators should not be given powers over the selection of those entering education.<sup>6</sup> For example, The General Chiropractic Council stated:

We do not consider that it is the business of the regulators to select students entering education. It would be impractical and costly to administer. We take the view that it is the role of regulators to have assurance that providers are running an effective selection system and implementing appropriate student fitness to practise procedures.

- 6.76 The General Medical Council argued that:

This would duplicate and usurp the roles of undergraduate educational institutions. It is also important to be clear that the individuals concerned would not at that stage be regulated professionals and so intervention by the regulator would be inappropriate. The regulator does, however, have a legitimate interest in the standards applied by educational institutions themselves in selecting students who, in time, may become registrants.

<sup>6</sup> Of the 192 submissions which were received, 54 expressed a view on this question: 6 said that the regulators should be given such powers, whilst 48 disagreed.

- 6.77 The British Psychological Society believed that the involvement of the regulators in the selection process would be “unwieldy and unworkable across a range of professions”.
- 6.78 The Medical Defence Union thought that “the selection process for healthcare students is far too remote from the regulators and they are better to concentrate on the curriculum and in assessing the quality of the institutions”.
- 6.79 An individual consultee (Jacqueline A Wier) noted that the proposed power would be “both unwelcome and unnecessary”. The British Society of Hearing Aid Audiologists did not consider that “regulators would add to the quality or effectiveness with which students are selected”. Furthermore, consultees also doubted that the regulators’ involvement in selection would add “patient safety value” (Royal Pharmaceutical Society of Great Britain).
- 6.80 The General Dental Council felt that the “existing legislation ensures fairness and equality of opportunity and it is for the institutions to ensure that they adhere to the law”. Several consultees agreed that selection was the proper responsibility of the institutions, including the Institute of Medical Illustrators who said that “the onus falls on the educational providers to ensure their graduates are ‘fit for purpose’”.
- 6.81 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that the regulators should only be given such powers in relation to post-registration qualifications “where it will be a pre-requisite to have a recognised qualification”. The Patients Association also suggested that direct regulator involvement may be more useful at the postgraduate stage “when graduates are specialising and particularly where they have direct contact with patients and service users in either a supervised or unsupervised fashion”.
- 6.82 The Department of Health argued that the selection of students should be left to education institutions but the regulator should have the power “as part of the standard setting or more generally, to specify selection criteria, for example two years post-registration experience” where this is important for public safety.
- 6.83 The Association of Clinical Biochemistry did not support the regulators having powers over selection, but did think that they “need to make clear to educational institutions who select candidates whether there are any issues that may render some applicants unregistrable at the outset”. The Royal College of General Practitioners also thought that some input from the regulators at an early stage in the process would be useful. It argued that “the regulator should set the standards for selection, but that it would be left to educational bodies to demonstrate that they meet those standards”.
- 6.84 The Scottish Government disagreed with extending the regulators’ powers in this area, but it felt that a Memorandum of Understanding between regulators and education providers might assist.
- 6.85 A small number supported giving the regulators powers in this area. For example, the British Medical Association argued that:

This allows the promotion of the key values of fairness, transparency, and widening access ... it is important that the regulator has a role in

the medical school selection process to ensure that it is as fair and transparent as possible, and that there is equity in access. Selection to medicine is an important step to becoming a doctor for applicants from an extremely diverse range of backgrounds and qualifications, and is the gateway to a medical career.

6.86 The Nursing and Midwifery Council argued that:

Whilst education institutions set the level of education to be achieved (meeting EU requirements where appropriate), regulators should be able to set entry criteria within their standards to reflect the professional attributes required.

6.87 The Academy of Medical Royal Colleges suggested that “the regulator should set standards for selection but not necessarily prescribe the exact method”.

6.88 The Northern Ireland Practice and Education Council for Nursing and Midwifery for Nursing and Midwifery believed that “regulators should have a view with regard to the application and selection of individuals wishing to enter a pre-registration programme for a profession”.

6.89 Optometry Scotland was of the view that the regulators “do control those entering education through the standard setting process”.

**Question 6-7: Could our proposals go further in providing a framework for the approval of multi-disciplinary education and training, and if so how?**

6.90 A small majority felt that our proposals could not go further in providing a framework for the approval of multi-disciplinary education and training.<sup>7</sup> For example, the Health and Care Professions Council pointed out that it already produces:

standards of education and training which are applicable across 15 professional groups, which help to facilitate multi-disciplinary education and training, and the approval of multiple programmes at multi-professional approval visits.

6.91 The Royal College of Obstetricians and Gynaecologists said that:

Unless the whole philosophy of healthcare education is revisited, it is difficult to envisage a framework that would be sufficiently meaningful to the professions or to education providers.

6.92 The Royal College of General Practitioners suggested that:

Guidance on the regulation of multi-disciplinary education may well be useful – with the strong reservation that multi-disciplinary education is not always an appropriate model, that it should not be

<sup>7</sup> Of the 192 submissions which were received, 44 expressed a view on this question: 14 said our proposals could go further, 23 disagreed, whilst 7 held equivocal positions.

the place of these proposals to push this model, and that its extent should be left to the determination of the professions themselves.

6.93 The General Optical Council stated that:

Ensuring that enough flexibility is available in how and what we accredit would allow for multiple disciplinary training, but this should not be at the expense of our ability to assess against profession-specific requirements (for example competencies and practical experience). This may be more relevant to NHS-funded training.

6.94 The General Medical Council thought that it “would be helpful if the statute provided a facilitative framework which would permit the approval by different regulators of multi-disciplinary education and training”. The Academy of Medical Royal Colleges agreed with the idea of a framework, that could be used by regulators at their discretion.

6.95 Some consultees supported the concept of multi-disciplinary education and training, but were cautious about whether the Law Commissions’ reforms could deliver significant change. The Registration Council for Clinical Physiologists argued that multi-disciplinary training and education should be encouraged “but that this is not an area which should be dealt with in statute”. An individual consultee (Don Brand) said that “substantial shifts of attitude and practice on the parts of the professions involved” was a prerequisite for change. NHS Education for Scotland agreed that this was not a matter for statute, but suggested that “evidence of interprofessional education could be required in the regulatory process”.

6.96 In respect of multi-disciplinary training, the Department of Health argued that:

We consider that if there was more coherence between the approach to standard setting and quality assurance of education and training it would be easier to provide some level of global approval for multi-disciplinary education and training. If multi-disciplinary education and training become more prevalent, a framework for it might eventually be helpful.

6.97 The Scottish Government argued that more work is needed to develop a framework for multi-disciplinary education and training.

6.98 The Department of Health, Social Services and Public Safety for Northern Ireland supported a framework for multi-disciplinary education “where common standards apply”.

6.99 However, some felt that our proposals should go further. The Centre for the Advancement of Interprofessional Education argued that:

Common studies are not enough to further collaborative practice unless and until they are complemented by interactive learning between the professions. Hence, an increasing emphasis on joint interprofessional education between the professions, the universities and the service delivery agencies, supported by the regulators, is strongly advocated. Each university mounting courses for the medical



health and social care professions should be required to present an interprofessional education strategy.

6.100 The British Pharmaceutical Students' Association stated that:

We would welcome a move towards compulsory multi-disciplinary education and training within the Masters of Pharmacy course. Making approval of multi-disciplinary education and training a compulsory component of course accreditation would ensure Schools of Pharmacy, and other health care courses, implement this solidly within their courses.

6.101 Coventry and Warwickshire Partnership Trust suggested that “a common first year syllabus for undergraduate training” might offer “greater opportunities for students to make career choices with a degree of knowledge and understanding of the roles” and “facilitate better multi professional learning and development for the future and reduce some of the barriers to multi disciplinary working that are currently visible”. However, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group disagreed with a common first year which it felt would lengthen the programmes and have funding implications.

**Question 6-8: Is too much guidance being issued by the regulators and how useful is the guidance in practice?**

6.102 Opinion was divided on whether too much guidance is issued by the regulators,<sup>8</sup> and in respect of its usefulness.<sup>9</sup>

6.103 Some were critical of the regulators' approach to guidance. For example, the Medical Protection Society argued:

We believe that, in general, there is too much guidance some of which is too prescriptive. It becomes difficult for professionals to make themselves aware of the published material, which obviates against its purpose.

6.104 The Royal College of General Practitioners stated that:

It is a common complaint from our members that the General Medical Council issues too much guidance and it is difficult for the busy professional to keep track of all developments. This is of particular concern, for example, where guidance has a bearing on fitness to practise, as with the Council's *Good Medical Practice* – guidance like this needs to be succinct, clear and specific, to avoid confusion and distress.

6.105 The Medical Defence Union gave the following example:

<sup>8</sup> Of the 192 submissions which were received, 24 expressed a view on this question: 7 said there is too much guidance, 8 disagreed, whilst 9 held equivocal positions.

<sup>9</sup> Of the 192 submissions which were received, 23 expressed a view on this question: 7 said all the guidance was useful, 6 said most was useful, 4 said only some was useful, 3 said the guidance was sometimes unhelpful, whilst 3 said this depends on the regulator.

If *Good Medical Practice (GMP)* is classified as the General Medical Council's code of conduct, it might be assumed that guidance provided supplementary to that document is intended as "ethical guidelines and other guidance" because this supplementary guidance is intended to provide more detail of how to comply with *GMP* and so it could be assumed it has a different status. But for doctors who are required to comply with the guidance, it is often difficult to distinguish between the different documents and to try to determine their status. *GMP* frequently refers readers to relevant supplementary guidance and has numerous footnotes on each page, while the supplementary guidance begins by referring to *GMP*. The effect of this in practice is that the distinction between the different documents is largely artificial. All guidance is relevant and it is probably safer for doctors to assume that all documents have equal weight.

- 6.106 It argued that "to add further to the confusion" doctors need to consider guidance available from other bodies and ask "whether it in any way supersedes or is supplementary to the guidance produced by their own regulator".
- 6.107 The General Social Care Council considered that "professional regulators should pay greater attention to the efficacy and usefulness of guidance before issuing it". It suggested that the Professional Standards Authority "may wish to conduct an audit of the range of guidance which is currently available ... and how and whether this conflicts and overlaps".
- 6.108 The Academy of Royal Medical Colleges thought that guidance was generally helpful, but noted that "regulators should be aware of the dangers of consultation and guidance overload". The Pharmaceutical Society of Northern Ireland also acknowledged the "danger of overload", but did not consider that it would be "acceptable for a regulator not to issue any form of guidance in relation to standards it is responsible for enforcing".
- 6.109 Many felt that in practice, few practitioners read the guidance from their regulatory body, and some emphasised the role of professional bodies in producing effective guidance. The British Society of Hearing Aid Audiologists stated:

We strongly believe that quality of guidance is only assured if it has been produced with the involvement and approval of professional bodies. We believe that regulators should not assume the role of professional bodies but should work very closely with them in the production of guidance. An effective partnership between regulators and professional bodies minimises unnecessary duplication of guidance and should add weight and authority to such guidance when both regulators and professional bodies are in agreement with what such guidance should contain and how it should be reviewed.

- 6.110 The Society and College of Radiographers stated that:

Guidance produced by regulators should be complementary with that produced by professional bodies and should also take account of the fact that employers will also issue guidance affecting practise of registrants.

- 6.111 Coventry and Warwickshire Partnership Trust felt that an agreement should be formed by the Government, regulators and professional bodies “on who provides guidance on what and a process to ensure that it supports rather than conflicts”.
- 6.112 Charles Russell LLP expressed concerns about General Pharmaceutical Council guidance which registrants are expected to adhere to which is not publically available and can only be accessed by Royal Pharmaceutical Society members.
- 6.113 However, some argued that it is important for the regulators to issue guidance, and that the professions welcome clear statements from the regulator. For example, an individual consultee (Stephen King) felt that as a podiatrist the Health and Care Professions Council “does not give too much guidance and what it does is useful”. The Association of Clinical Biochemistry agreed that the Council issues the right amount of guidance.
- 6.114 The British Psychological Society felt that guidance was useful to “balance some of the pressures that come from employers and to provide support to members if there is a conflict of interest”. The British Association for Counselling and Psychotherapy thought that guidance was “likely to respond to frequently asked questions”.
- 6.115 The Royal College of Nursing believed that there are certain topics on which the Nursing and Midwifery Council issues guidance – for example vulnerable adults, medicines management, accountability – which are “very important and helpful to practicing nurses”. However, it noted “that it is difficult to know how consistently such guidance is implemented and therefore what impact it has”.
- 6.116 Skills for Care believed that the regulators of social care professionals have issued an appropriate amount of guidance. It was concerned that this should not be lost in the transition from the General Social Care Council to the Health and Care Professions Council.
- 6.117 The Nightingale Collaboration argued that “too little guidance” is issued by the General Chiropractic Council and General Osteopathic Council and more is needed on the scope of practice in order to prevent practitioners from misleading the public about which conditions can be treated effectively by these professions.
- 6.118 The General Osteopathic Council noted that the answer to the Law Commissions’ question would “depend on the profession concerned”. The Council pointed out that osteopaths only receive one piece of guidance.
- 6.119 The General Medical Council warned against dismissing “what might seem high level and generalised statements in some guidance”. It said that:

The consultation document questions the value of guidance which prohibits sexual relations between healthcare professionals and their patients because such principles should be obvious. The fact remains, however, that regulators continue to have to take action in relation to individuals who have disregarded guidance in this area. The fact that we know sexual assault is wrong does not remove the need for the Sexual Offences Act. The existence of the guidance establishes expected principles of professional behaviour and helps

regulators frame the appropriate sanctions when those standards are ignored.

- 6.120 It argued that the quantity of guidance produced often reflects the fact that it will frequently have more than one audience and be used in a variety of different contexts. It stated that:

General Medical Council guidance will usually be directed primarily at doctors, but it will also have implications for employers (as in the case of NHS appraisal), educators (the development of curricula and outcomes for training), and for the way patients understand what they can expect of their doctors (we plan to introduce a patient version of our core guidance *Good Medical Practice* in 2012).

- 6.121 It was also argued that General Medical Council guidance often underpins the guidance provided by other bodies, such as the medical defence organisations, the British Medical Association and the medical Royal Colleges.

- 6.122 The Health and Care Professions Council argued that:

The level and volume of guidance published will inevitably vary from regulator to regulator – dependent on factors such as how developed the “professional infrastructure” in each profession is (eg the existence of professional bodies and colleges) and whether the regulator regulates a single profession or a number of professions.

- 6.123 The Nursing and Midwifery Council disagreed that there should:

be a presumption that if a topic is covered elsewhere, for example, through National Institute for Clinical Excellence standards or workplace guidelines, it should not also be the subject of guidance from regulators. The “contract” between a regulator and its registrants demands that registrants have a right to clarity about which aspects of practice are critical to their continued registration.

- 6.124 Similarly, the General Optical Council argued that:

The fact that guidance is produced by another related regulator or other organisation should not preclude more tailored guidance being issued by regulators for their own audiences.

- 6.125 The Professional Standards Authority stated that:

There are clearly many areas of commonality in the work the regulators undertake that would benefit, from the perspective of the intended audiences, from a common or shared approach. For example, guidance for education providers on student fitness to practise is something that could perhaps be usefully produced as a single piece of guidance.

- 6.126 Furthermore:

We have tried to gather information from the regulators about the impact of their guidance on registrants through our annual performance review, but this has not yielded much data. For individual registrants we are aware, from a literature review we commissioned recently on the major behavioural influences on health professionals' performance, that there is little if any evidence supporting the effects of regulators' guidance on behaviour.

- 6.127 The Scottish Government argued that "it is for the regulators to ascertain the volume of guidance produced in accordance with their statutory functions". However, it wanted to explore further whether the statute could encourage joint guidance in some areas and help clarify "the roles of regulators and professional bodies in developing and disseminating guidance and ensuring good practice".

**Provisional Proposal 6-9: The statute should require the regulators to issue guidance for professional conduct and practice.**

- 6.128 An overwhelming majority agreed with this proposal that the regulators should be required to produce guidance for professional conduct and practice.<sup>10</sup> For example, the Professional Standards Authority stated that:

It is very difficult, if not impossible, to see how the regulators can successfully protect the public in the absence of fundamental core standards of conduct and practice.

- 6.129 The National Clinical Assessment Service supported the need for clear guidance provided by the regulators and also suggested a single code of conduct across all regulated professionals. NHS Education for Scotland also supported a single code.

- 6.130 Some consultees thought that guidance for professional conduct and practice was an important source of information for the public. For example, the Nursing and Midwifery Council said that such guidance is:

the means by which the assurance provided by professional regulation is made manifest to the public, and by which registrants understand how they can remain in good standing.

- 6.131 An individual consultee (Jane C Hern) also agreed that guidance assisted "both the profession and the public".

- 6.132 The General Optical Council and the Royal College of Nursing both noted that the proposal reflects current practice.

- 6.133 Some suggested specific amendments to the proposal. NSPCC argued there should be a duty on the regulators "to include the issue of safeguarding of vulnerable children in their codes of practice or codes of conduct". The London Fire Brigade suggested that the codes should require registrants to identify fire risks and for training to be mandatory. Many questioned whether "guidance" is the appropriate term for a professional code of conduct.

<sup>10</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 disagreed.

6.134 A small number disagreed with the proposal. Optometry Scotland argued that “guidance should be provided by the professional bodies and not placed in statute”. The Optical Confederation suggested that the duty should be to “ensure that guidance is issued” therefore enabling the retention of the current system “by which the College and the Association of British Dispensing Opticians develop guidance for the two professions which is then endorsed by the regulator”.

**Provisional Proposal 6-10: The statute should provide for two separate types of guidance: *tier one guidance* which must be complied with unless there are good reasons for not doing so, and *tier two guidance* which must be taken into account and given due weight. The regulators would be required to state in the document whether it is tier one guidance or tier two guidance.**

6.135 Opinion was divided on the proposal that the statute should provide for two tiers of guidance.<sup>11</sup>

6.136 The Association of Regulatory and Disciplinary Lawyers felt that the proposal would be “a helpful clarification given the amount of guidance being issued”. The Royal College of Nursing agreed there can be confusion between various types of guidance and standards, and that the regulators should be clear “about the purpose and weight of communications which they issue, for example being clear about how they expect registrants to use them”.

6.137 The General Dental Council felt the proposal reflected the approach adopted by its Standards Review Working Group which has developed new guidance consisting of “patient expectations, standards and guidance” whereby “the standards equate to tier 1 (the mandatory ‘what’) and the guidance to tier 2 (advice on the ‘how’)”. The Council agreed that guidance must clearly state its legal status and “the possible consequences of serious or continued breaches”, and “the language in guidance should be consistent between regulators”.

6.138 An individual consultee (Jane C. Hern) felt that the proposal would be helpful “to highlight and distinguish the ‘must do/not do if at all possible’ from the more aspirational ‘good practice’”. The Patients Association felt that the statute should also set out “a defined list of those areas that ‘must’ be tier one guidance, for example professional standards”.

6.139 The Medical Protection Society argued that the proposed two tier approach would be clearer “than the General Medical Council’s current use of the words ‘should’ and ‘must’ which can be confusing”. The Royal College of General Practitioners also observed that *Good Medical Practice* included a diverse range of activities or failures which “potentially put a doctor in breach, where some might appear relatively trivial where others are clearly very serious”.

6.140 Optometry Scotland noted that a “two tier approach was introduced by the College of Optometrists some time ago and is endorsed by the General Optical Council”. It saw no reason to amend this system.

<sup>11</sup> Of the 192 submissions which were received, 60 expressed a view on this proposal: 25 agreed, 22 disagreed, whilst 13 held equivocal positions.

6.141 The Institute of Health Visiting agreed with the proposal but was concerned that “‘tier two’ guidance should not be seen as optional, if it is about good practice”. The Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal but argued that issuing second tier guidance should be a function of the professional body.

6.142 The Professional Standards Authority was supportive of the intentions behind the proposal but said:

We can foresee a situation arising where potential inconsistencies may arise if one regulator classifies something as tier one when the same guidance is classified as tier two by another. This could prove problematic for multidisciplinary teams, especially if concerns arise about fitness to practise.

6.143 It was suggested that the statute should identify “requirements” and “guidance”, or provide for two types of guidance, “one a ‘must do’ and the other a ‘how to’”.

6.144 The Osteopathic Alliance was also concerned about the impact of two tiers of guidance in fitness to practise proceedings. It thought that, if the proposal was adopted, it should be:

written into the statute that it is an acceptable defence that in the clinician’s considered clinical judgment at the time it was not appropriate to follow that guidance, whatever the outcome.

6.145 However, some disagreed with this proposal. The Department of Health, Social Services and Public Safety for Northern Ireland questioned how the courts would interpret this proposal and felt it was unhelpful to distinguish between mandatory and optional guidance.

6.146 The Health and Care Professions Council felt that its governing legislation already provided clarity “about the distinction between standards and guidance” in that “standards set a requirement which must be met by a registrant or an education provider” and “guidance sets out ways in which those standards might be met”.

6.147 The British Chiropractic Association thought that two tiers of guidance may “produce unnecessarily cumbersome Codes of Practice and Standards of Proficiency which may serve to leave registrants unsure of their obligations”. The Department of Health felt that having two tiers of guidance might be helpful in some cases but was concerned that this approach may become “overly complicated”. It suggested that it might be better to “first consider what sort of issues need guidance and then decide if the regulators should be required to issue such guidance or have discretion”.

6.148 The General Medical Council felt that the proposal:

fails to recognise the extent to which our guidance is integrated into all of our regulatory functions, from education to fitness to practise. This sort of disaggregation of the standards would bring practical problems. The assumption would appear to be that failure to observe tier one guidance would result in fitness to practise action. But the

implications of persistent and cumulative disregard of tier two guidance are less clear even though this may have a significant bearing on an individual's professional performance.

- 6.149 It contended that *Good Medical Practice* already recognises “the nuances of distinction between guidance which must be complied with and behaviours which should be followed” through the use of “must” and “should”. The Council argued further that the proposal:

fails to recognise the extent to which tiers might apply differently across different UK jurisdictions, thus adding unnecessary and dangerous complexity to the challenges of regulating a common set of enforceable standards across the four countries.

- 6.150 The Medical Defence Union felt that in practice it is “almost impossible to distinguish between guidance that must be complied with and guidance that must be taken into account and given due weight”. It argued that:

If a regulator publishes guidance and it is in the public domain, in practice the registrant has to comply with it unless he or she can demonstrate good reasons to do otherwise.

- 6.151 The Scottish Government agreed that “benefit could be obtained from having the two tiers of guidance proposed” but suggested that “exemplars already exist which could provide a starting point” such as *Good Medical Practice*. It was also concerned that there is the potential for disparity between the regulators “for example in determining which areas are tier one or tier two, which would serve to confuse the public and result in less rather than more transparency”.

- 6.152 It also pointed to the use of “must” and “should” in *Good Medical Practice*:

We do not see the distinction between must and should as producing two-tier guidance but as recognition from the regulator that in some circumstances all registrants are required to comply, but in others, registrants are required to comply only as far as is in their power and as it is reasonable for them to do.

- 6.153 The General Pharmaceutical Council felt that its own approach, whereby a “‘standard’ is something which must be met”, whereas guidance is a non-mandatory “description or advice about how to meet the standard”, was more consistent with the ordinary use of the term “guidance”. It also argued that the proposal may not achieve any clarity of definitions of standards and guidance because professional bodies also publish “a range of guidance and use a range of descriptors such as ‘standards’ or ‘guidance’ or advice ‘bulletins’”.

- 6.154 The General Osteopathic Council pointed out that while the *Osteopathic Practice Standards* differentiates between standards that must be complied with and associated guidance, the reality is more finely nuanced.<sup>12</sup> The Council said:

<sup>12</sup> General Osteopathic Council, *Osteopathic Practice Standards* (2012).



In the *Osteopathic Practice Standards* we draw a distinction between “must”, “may” or “should” to guide and support osteopaths in their professional decision-making. This immediately suggests that more than two tiers may be required ... We believe that this is an area where it would be better for the regulators to continue to evolve individual approaches and for best practice and innovation to emerge without a single prescribed approach.

- 6.155 The General Social Care Council also felt that the regulators should be given “maximum flexibility” to issue guidance and standards. It argued that:

Whilst the guidance and standards that are issued by regulators are important, it is ultimately for the registered professional to take responsibility for their practise. Whilst guidance and standards may be useful in informing this practise professionals themselves should be trusted to make decisions without the need to refer, in advance, to guidance. They should be held to account against the standards issued by the regulator but also against standards issued by other bodies.

- 6.156 Many commented on the terminology used in the proposal. The Academy of Medical Royal Colleges argued that calling both tiers “guidance” can be confusing “as requirements are rules and guidance is advisory”. The Nursing and Midwifery Council preferred the terms “code” and “standards” since they have “meaning and currency in professions and should be retained”.

- 6.157 The General Optical Council was not clear what was added by “the proposed terminology of ‘tier one’ and ‘tier two’ guidance ... relative to the current distinction between standards/codes and guidance”. It felt that the word “guidance” itself implies that it is non-binding and therefore “the concept of binding guidance may cause confusion”. The Council also questioned whether the:

distinction between tier one guidance that “must be complied with *unless there are good reasons for not doing so*” and other guidance that must be “taken into account” is sufficiently clear.<sup>13</sup>

- 6.158 The Pharmaceutical Society of Northern Ireland agreed with the rationale behind the proposal but preferred its own system whereby mandatory professional standards are indicated by “must” and “have to” and guidance on good practice is indicated by the words “should”, “might”, “may”, “would”, “will” and “could”.

- 6.159 The Society and College of Radiographers felt that the use of terms such as “tier one guidance” is less important than “stating clearly the importance of the document”, for example that “this guidance is important to your registration and ability to work”.

- 6.160 Unite believed that “tier two guidance should not be reduced to ‘nice to do if we have the money’, which would mean that it would be unlikely that it would be done”.

<sup>13</sup> Emphasis added.

**Question 6-11: How should the legal framework deal with the regulators' responsibilities in relation to professional ethics?**

- 6.161 Opinion was divided over how the statute should deal with professional ethics.<sup>14</sup>
- 6.162 Some called for a clear separation between ethics and standards. The Association of Regulatory and Disciplinary Lawyers argued there is an “important distinction between standards of practice (conduct and performance) and ethical codes, and the latter should be “in the form of a set of core principles which are common across all the health and social care regulators, which would be in the interests of clarity for the public”. An individual consultee (Lucy Reid) felt that practitioners would welcome a separate requirement for the regulators to provide ethical guidance and while there is some overlap with standards for practice, ethics can be “more sensitive to the nuances of the situation”. Coventry and Warwickshire Partnership Trust also agreed that it “would be useful if the regulator clearly separated ethics and standards”.
- 6.163 Others pointed to the difficulties in making a clear distinction. The Medical Defence Union felt “it is often difficult and anyway not necessary to separate ethics from conduct and practice” and “if ethical guidance is relevant to practice it should be incorporated into guidance on conduct and practice”. The General Osteopathic Council disagreed that “ethical standards should be treated separately from standards of conduct and performance” since “together they provide a framework for professional behaviours to be exercised and within which fitness to practise is a requirement”. The Association of Clinical Biochemistry regarded ethical guidelines as “a sub-set of codes of practice”.
- 6.164 The General Dental Council provided the following example:
- Respect for a patient is an ethical approach but it is demonstrated by actions covered in standards in varied ways such as the giving of adequate information, checking that the patient understands, encouraging shared decision making and referring on if appropriate.
- 6.165 The General Medical Council argued that it would be helpful:
- to start from the premise that ethics deals with discussion and understanding of an issue while “standards and professional conduct” provide advice on how to put ethics into practice. On that basis, we could regard regulators’ role in providing advice on ethics as a statutory power, but advice on standards and conduct as a duty.

<sup>14</sup> Of the 192 submissions which were received, 37 expressed a view on this question: 6 said that professional ethics should be dealt with separately, 12 said this should be dealt with within professional standards, 7 emphasised the role of the regulator, 9 emphasised the role of professional bodies, 2 said that there should be uniform code of ethics across the regulators, whilst 1 gave an equivocal response.

- 6.166 The General Optical Council felt that regulators did have some role in relation to ethics, which should be set out in the statute. However, the Council also wished to retain flexibility about how it discharged its role. The Department of Health stated that the regulators' responsibilities "in relation to professional ethics should be related to public protection and the overall suitability of a professional's fitness to practise".
- 6.167 Many argued that ethics are not a matter for the regulator. The British Association for Counselling and Psychotherapy argued that "the development of ethics is the responsibility of the profession" and "the use of those ethics in conduct matters is for the regulator". Similarly, the British Medical Association argued "it is for professions to determine appropriate ethical standards and for the regulator to apply them, taking into account any relevant legislation". However, Unite argued that "the legal framework should ensure that regulators are not solely relying on professional body guidance as membership of a professional body is optional".
- 6.168 The Professional Standards Authority disagreed with giving regulators responsibility for professional ethics since "it is more appropriate and accessible for all stakeholders to cover these issues within a framework of professionalism". The Scottish Government considered that "professional ethics are an integral part of an individual's character and suitability to be a registered healthcare professional" and "given that the distinction between standards and ethics cannot be sharply defined" they should not be separated in the legal framework.
- 6.169 An individual consultee (Dr Susan Blakeney) argued that the statute should retain existing arrangements whereby the College of Optometrists produces the *Code of Ethics and Guidelines for Professional Conduct* which supplements the General Optical Council's Code of Conduct.
- 6.170 The Nursing and Midwifery Council argued that:
- What matters is that the framework for professional regulation supports and requires regulated professionals to take professional responsibility for navigating the ethical complexity with which they work. It is also important that regulators provide a framework within which that important work is done, including through the use of professional codes.
- 6.171 The British Association of Social Workers felt that the "code of conduct/ethics should be enshrined in statute and common to all the health care professions". Similarly, the Professional Forum of the Pharmaceutical Society of Northern Ireland argued that the "minimum standards, the 'do no harm' statements" could be common across all health care professions. The General Social Care Council also suggested that the statute:
- should require regulators to issue standards in relation to ethics, however, they should be encouraged to develop common standards of professional ethics governing all the professions subject to regulation. There is no good reason why the ethical behaviour of a doctor should differ from that of a social worker.

**Provisional Proposal 6-12: The statute will require the regulators to ensure ongoing standards of conduct and practice through continuing professional development (including the ability to make rules on revalidation).**

- 6.172 The vast majority agreed with this proposal.<sup>15</sup> For example, the Professional Standards Authority said that the “statute should oblige regulators to make rules in this area”. The Authority also said that the statute should:

make provision for an appropriate and proportionate response from regulators to changes in risks associated with ongoing standards of conduct and practice over time.

- 6.173 The British Association and College of Occupational Therapist saw the Authority itself as having a “strong role to play” in encouraging the sharing of good practice in this area.

- 6.174 The Royal College of Physicians of Edinburgh stated that the duty to ensure ongoing standards will require the regulator “to work closely with the medical Royal Colleges”. The Medical and Dental Defence Union of Scotland argued that continuing professional development “must reflect the sphere of work the registrant is engaged in and therefore must be relevant” and argued that in dentistry continuing professional development “is too input focussed and could be construed as a ‘tick box’ exercise”. Unite recommended the Health and Care Professions Council’s approach to continuing professional development “which is standards based and emphasises application of knowledge to practice and insists on a mixed format of continuous learning”.

- 6.175 The Institute of Health Visiting expressed concern about the “lack of rigour concerning continuing professional development for health visitors”, arguing that portfolios are rarely audited and there is no requirement for “relevant learning”. It stated:

This means that some employers claim their staff have met all their continuing professional development requirements if they have attended, eg annual fire, moving and handling and cardiac resuscitation study days, which easily covers the requisite 35 hours in three years. However, it will not have advanced or even maintained the practitioners’ professional knowledge or skill in their particular field.

- 6.176 The Institute also argued that because health visitors are regulated primarily as nurses or midwives, the Nursing and Midwifery Council requires them to demonstrate the completion of “450 hours current practice in nursing or midwifery, as well as in specialist community public health nursing”. This causes particularly difficulties for “direct-entry midwives” who unlike nurses are not allowed to “double count” their hours.

<sup>15</sup> Of the 192 submissions which were received, 56 submissions expressed a view on this proposal: 54 agreed, whilst 2 disagreed.

- 6.177 NHS Greater Glasgow and Clyde pointed to the difficulties caused by the Nursing and Midwifery Council when it introduced a requirement that midwives must demonstrate a specific number of hours in “delivery” per year. This had to be abandoned when it became apparent that midwives working in special care baby units could not satisfy this requirement.
- 6.178 The Royal College of Nursing expressed concern that employers do not always allow nurses to undertake continuing professional development and felt that in the current economic climate this will increase. It also criticised the Nursing and Midwifery Council for not routinely checking nurses’ post-registration education and practice portfolio.
- 6.179 Some consultees suggested enhanced duties in this area. For example, the Nightingale Collaboration argued that the statute should place a duty “on the registrant to review and take account of new scientific evidence and meta-analyses” and ensure that “all practice must be based on the consensus of sound scientific evidence”. The Osteopathic Alliance argued that that the power to set standards for continuing professional development should be limited to those areas with a direct bearing on patient safety. It also pointed out that:

requirements for continuing professional development have a financial impact not just for organisations such as the NHS but also for practitioners in private practice (including most osteopaths), who will have to take unpaid time out of work to provide the evidence.

- 6.180 The Optical Confederation argued that that the statute should not require ongoing standards of conduct and practice *through* continuing professional development but instead the regulators should be able to consider other means of achieving the same ends. Similarly, an individual consultee (Anonymous) argued that in an era of right-touch regulation, it should be open for the regulators to argue that the ongoing standards can be maintained through “the standard setting in education and fitness to practise process” and that it should be “for employers and individual practitioners to ensure their on-going fitness to practise”.
- 6.181 West Sussex County Council thought that:

The key to [that] continuing professional training and learning is not a rigid compliance with competencies for practice but the ability to demonstrate such competencies within the context of critical reflection and practice analysis.

### **Revalidation**

- 6.182 A number of consultees commented specifically on revalidation. The Patients Association argued that revalidation should be part of the continuing professional process and enshrined within the statute. It felt that:

It does not seem logical to have continuing professional development but not revalidation. Revalidation makes sure that the information gathered during continuing professional development is properly assessed as well as ensuring codes of practice are being followed by practitioners.

- 6.183 The Scottish Government argued that “the intensity and frequency of revalidation for the health care professions should be proportionate to the risks inherent to their work”. It also argued that “a degree of oversight and scrutiny/monitoring would be needed in relation to the introduction of revalidation” in order to ensure “proportionality and effectiveness and minimising costs” and to “identify any issues that may affect individuals’ performance rather than being picked up at a later stage eg at fitness to practise hearings”.
- 6.184 The General Pharmaceutical Council stated that it already requires all registrants to complete continuing professional development records and it needs powers “to make rules in connection with continuing fitness to practise (revalidation)”. It endorsed the key principle of revalidation that evidence of conduct and practice would be required from more than one source and not solely continuing professional development records.
- 6.185 The British Pharmaceutical Students’ Association supported giving the General Pharmaceutical Council powers to introduce revalidation. The General Dental Council welcomed “the recognition that revalidation will be a part of the future healthcare regulatory landscape”.
- 6.186 The Association of Clinical Biochemistry supported the proposal but was concerned over “the potential for revalidation systems to be disproportionately burdensome and expensive to run”. Optometry Scotland stated:

We would hope that the revalidation process is left to the discretion of the regulator so this is fit for purpose and proportionate to the risk to the public. In addition the process should be flexible to cover different standards of clinical practice across the UK.

- 6.187 The Welsh Government argued that “it is important that any costs are proportionate to the benefits of introducing revalidation for all professionals”.
- 6.188 The Medical Defence Union argued that “given that most practitioners within the NHS are practising in managed environments and their institutions are also subject to regulation” it must not be assumed that revalidation is the most effective way of protecting patients. Any introduction of revalidation must be “subject to strict cost-benefit analysis” and the regulator should be required to demonstrate that revalidation would bring “substantial additional benefits for public protection that justify the additional and substantial cost and administrative burden upon the profession”.
- 6.189 The Department also wanted to explore further whether there is scope for the regulators to have powers to “quality assure assessments made on the professional standards of staff” to ensure “local processes are working effectively rather than waiting until an issue is raised through fitness to practise procedures”.
- 6.190 The Health and Care Professions Council felt that greater clarity was needed over what is meant by revalidation and how this differs from continuing professional development. Furthermore:

The introduction of any revalidation system should be subject to a formal impact assessment and public consultation ... The regulators will consider impact and risk as a standard part of their policy

development and consultation processes. However, unlike government departments and non-departmental public bodies, they may not routinely produce formal impact assessments ... We are particularly supportive of an express requirement to publish an impact assessment before implementing revalidation or establishing a voluntary register (a current requirement in the relevant legislation).

6.191 The Royal College of Radiologists emphasised that under revalidation “the focus should be on remediation with appropriate time allowances made for those involved in or assisting in the process”.

6.192 The Department of Health had concerns about the introduction of revalidation in the “non-medical professions”. It thought that:

At the very least the non-medical regulators should be required to publish an impact assessment for consultation before introducing any new requirements and should have to have regard to the principle of proportionality in setting any standards.