council for healthcare regulatory excellence

Discussion Paper: Early thinking on CHRE's potential role in operating a voluntary register scheme

December 2010

1.1 Background

The Council for Healthcare Regulatory Excellence (CHRE) promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for the training and conduct of health professionals. We share good practice and knowledge with the regulatory bodies, conduct research and promote the concept of 'right-touch regulation'.[1] We advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

1.2 The Department of Health's Review of Arm's-Length Bodies[2] set out a number of changes for CHRE which include extending our remit to 'set standards for and quality assure voluntary registers'. The reformed and renamed CHRE will be a public body with statutory duties and will be accountable to Parliament through the Privy Council.

1.3 Provision for these changes will be made in forthcoming legislation. The reforms are therefore still subject to government decisions, legislation and parliamentary approval. A Bill is expected to be published in January, after which we intend to publicise details of our work on the proposal that CHRE establish quality assurance scheme on our website in 2011 and, subject to Parliament's approval of this extension to CHRE's role, to work with interested groups to encourage their preparation for registration from April 2012 onwards.

1.4 This paper sets out our understanding of the roles and responsibilities that the Government intends us to have in the future with regard to voluntary registers and describes, in outline, the factors we think we might need to take into consideration in designing and operating such a scheme. A number of existing voluntary register groups have already approached us to discuss how the quality assurance scheme might work. It appears there is a genuine interest in and desire for this extension of occupational standards in the health and care sectors.

[1] CHRE August 2010 Right-touch regulation
[2] DH 26 July 2010 Review of arm's length bodies to cut bureaucracy

1.5 We are distributing this paper to gather views on our preliminary thoughts. At paragraph 6 we highlight some key issues.

2. The voluntary register scheme - assuring voluntary professional and occupational registration

2.1 The Government proposes that CHRE should have an additional role in strengthening patient safety by setting standards for voluntary registers and quality assuring them. It is proposed that CHRE would ensure that such arrangements are coherent and underpin joint working across health and social care. Voluntary registers would set standards for registration and for conduct and competence. They should have proportionate methods for removal from the register.

2.2 We agree in principle that the proposal to quality assure voluntary registers would promote the health, safety and well-being of patients and the public. However, in our view the introduction of an assured voluntary register scheme needs to be clearly distinguished from statutory regulation in order to avoid confusing the public and undermining the validity of either model. For this reason, we recommend that statutory regulators should not also hold voluntary registers as it is likely that the public may assume that the standards and controls are the same. This need not preclude statutory regulators from offering services to voluntary registers on a commercial basis, for instance managing a register on their behalf, but the two systems must remain visibly and distinctly separate.

2.3 **Purpose of the scheme**

2.4 Healthcare today comprises of many different disciplines, some involved directly in the provision of care, others in a support or ancillary function. In the UK, science based medicine is dominant but complementary healthcare models are increasing in popularity. Those disciplines which fall outside of the statutorily regulated groups are either self-regulated or for the most part unregulated beyond the usual remit of the laws governing commercial practice in the UK. Patients and the public are therefore left to make up their own minds about the efficacy of any treatments or services on offer.

2.5 The coalition government has made clear its plans to increase patients' choice and control over the health and social care services they receive; and the reforms set out in *Equity and Excellence: liberating the NHS* point to greater diversity of supply and the need for an agile workforce. We anticipate therefore that the professionalism of those who provide care or support its delivery will increasingly become the cornerstone of good quality care. Their personal adherence to standards of good practice offers the public front line protection and transcends all organizational forms.

2.6 Health and social care professionals are often reliant upon services provided by other occupational groups or interact with other non-statutorily regulated disciplines in the provision of care. For example, medical consultants rely on support from health informatic professionals, some being voluntarily registered and others unregistered. Patients may simultaneously access conventional medicine and alternative therapy.

2.7 The purpose of the voluntary scheme will be to encourage the development of professional conduct, ethical practice and high standards of performance in groups providing, associated with or affiliated to the delivery of health and social care, where statutory regulation is not necessary to protect the public. It would be founded on the principles of right-touch regulation and focussed on improving the quality of care, including patient experience.

2.8 It will aim to drive up professional (ethical) behaviour, establish standards, develop or clarify evidence bases and so increase the overall quality of care. It will underpin essential 'care transactions' whether between care professionals and the public or between care professionals themselves where one discipline relies on the conduct and competence of another.

3. Care transactions

3.1 The OFT consumer code scheme[3] works on the principle of restoring the balance in commercial relationships where the trader has an advantage through possessing technical knowledge on which the public have to rely e.g. a motor mechanic.

3.2 A 'care transaction' takes place in the context of a similarly unbalanced relationship. It may be part of a commercial transaction but generally takes place within the context of heightened vulnerability (access to intimate information and/or examination and weakened physical, emotional or psychological health). Care transactions take place within a number of disciplines from neurologist (regulated) to healer (unregulated).

3.3 Care pathways are changing, healthcare is becoming more dependent upon multi-disciplinary teamwork and patients more frequently cross the boundary between conventional western medicine and complementary therapies. The voluntary register scheme would provide an opportunity to support these developments, inform patient choice and increase public protection in a flexible, proportionate manner.

4. Potential clients

4.1 The size of the market and the economic impact of any scheme on existing voluntary registers, the public, employers and the workforce will need to be formally assessed. The voluntary register groups who have approached

[3] The Office of Fair Trading's Consumer Code Approval Scheme

CHRE and expressed an interest in the scheme vary in size from a couple of hundred voluntary registrants to thousands. The percentage of people working within the occupational group who register also varies from minor to a significant proportion of the workforce and seemingly tends to reflect the length of time a register has been in existence. Some groups have UK wide membership.

4.2 The characteristics of the voluntary register groups vary. Some voluntary registers employ staff but many are operated by volunteers. Their funds vary as does the salary range of their members and include employed, self-employed, part-time, and voluntary workers. Qualification levels and types also vary. The evidence base for the particular disciplines practiced differs from that of most statutorily registered bodies, with a stronger reliance on qualitative evidence. Some disciplines may not yet have an established evidence base but the public may benefit from its development (e.g. commissioning).

4.3 Motivations for voluntary register groups seeking to join the scheme include:

- Genuine concern to protect the public from risks they believe to exist. The extent of actual risk may occasionally have been tested
- Desire to raise the standards of practise by their occupational group and so the quality of care
- Increasing recognition and raising the status of their occupational group
- Imparting credibility to their discipline
- Access to expert guidance and support.

4.4 The scheme will need to take account of all of these motivations and their attendant benefits and risks including:

- A lever to drive up the quality of care by increasing the professionalism (adherence to standards) of groups who work in association with statutorily regulated professions (e.g. commissioning)
- Encouraging the development of a robust evidence base for those disciplines which lack it; or conversely transparency about the evidence status where either none exists or it is anecdotal
- Increasing the public's understanding of the standards of the various disciplines, and their evidence base and supporting patient choice by enabling them to make informed choices
- Adverse impact on CHRE's reputation by association
- Potential liability for legal cost in the event of dispute
- Inadvertently giving credence to ineffective disciplines
- Confusing the public.

5. What CHRE would do

5.1 CHRE's scheme would focus on the promotion of good quality care rather than on the avoidance of harm. Entry to the scheme would therefore not be dependent on the level of harm. Members will pay an annual fee, the amount of which is still to be determined.

5.2 The voluntary register scheme would be separate from CHRE's statutory role. It will have its own brand identity, a name, and either a separate website or a separate section on the CHRE website.

5.3 We will develop standards for admittance to the scheme, guidelines for the development of Codes of Practice and a self-assessment system for use by voluntary health and social care professional or occupational bodies that have or wish to establish their own registers of members. We may consider encouraging peer review.

5.4 We will admit groups to the scheme and will approve their Codes and governance arrangements. We will periodically assess organisational compliance which might be triggered by customer feedback. Groups may commission CHRE to review their arrangements directly but we envisage this to be by special arrangements rather than included as part of the standard fee in the interests of cost efficiency.

5.5 There are likely to be benefits in offering access to shared service provision, including a common register for the public to access.

5.6 **Potential eligibility criteria for professional/occupational groups**

5.7 We set about below our provisional thoughts on the arrangements we might want voluntary register groups seeking CHRE's approval to have adopted.

5.8 Before being considered for assessment for entry to the scheme, a group must demonstrate a primary intention to protect and promote the interests of care recipients. The group should demonstrate understanding of the difference between professional and public interests.

5.9 The criteria for acceptance onto the scheme and award of CHRE approval might include that a voluntary register group:

- Hold and administer a register of members with defined rules for entry, scope of practice, removal and appeal; and be able to evidence that they exercise proper authority over admittance to, continuance on and exit from the register. They should have proportionate methods for removal from the register

- Have a substantial membership. As accurate data may not exist this may be hard to quantify precisely so in line with the principles above, we suggest that we leave it to the group to demonstrate 'substantial'. We will need to make allowance for the fact that admittance to the CHRE scheme will

increase the legitimacy of the group and lead to an increase in membership and so levels may initially be relatively low

- Established governance systems and efficient operating systems that comply with the principles of good administration, deliver value for money and ensure delivery of the primary intention. The group should have defined its objectives and desired outcomes
- Have a clear understanding of the nature and extent of risk the practice of their discipline(s) pose to the public. This includes not just the avoidance of harm but also the failure to achieve intended benefits
- Defined the qualification/vocational training levels which must be commensurate with the degree of expertise required to carry out their professional role adequately and safeguard the public. Training must encompass the study of ethics as it relates to their professional role
- Established a robust method of assuring the quality of education and training courses
- Defined and codified standards governing professional practice including competence, conduct and learning Members must be required to notify the registrar of any breach of standards
- Established arrangements to ensure the ongoing efficacy of their standards and guidance for example to respond to law, research, ethics, public interests
- Have established an internal quality assurance system and undertake periodic audit/review of its systems
- Demonstrate active listening and engagement with the public
- Established arrangements for raising and handling concerns with a focus on early resolution
- Have safeguarding arrangements in place
- Members are part of an indemnity scheme.

6. Key issues

6.1 We set out below some of the factors we think raise important issues that affect the design of the scheme. Fundamental, is deciding whether the scheme is inclusive – and encompasses a broad range of occupations, or exclusive serving a defined minority. Deciding where to set the bar for entry to the scheme is likely to be critical to its success. CHRE might set the bar at a particular level which may temporarily or permanently exclude some occupational groups which might have positive or negative effects. A market impact analysis would be required to assess which approach should be taken. Some of the factors we need to consider are set out below.

- **Efficacy -** defining the type and extent of evidence base required for CHRE to approve entry of a profession into the scheme. If CHRE accepts voluntary register groups who practice disciplines that do not have a conventional evidence base (for example, based on randomized controlled trials) but has a body of anecdotal or other qualitative evidence it may increase public confidence in a particular treatment or discipline and at worst, may provide false assurance. If it excludes them, the public are denied the benefits that a benign influence, which encourages the development of standards and improved evidence, might bring.

- **Qualification levels –** the qualification levels and types vary with some groups preferring academic models and others vocational routes of entry; some restricting entry to higher qualifications and others casting the net wide. If 'professional' status is conferred on too wide a group it might devalue its status and act as a disincentive. However, achieving the recognition that such a status denotes is a powerful motivator.

- We might limit our scheme to those occupational groups who are self-directing rather than operating under instruction, close supervision or within narrowly defined parameters whose work is subject to employer led controls. However, we might also take account of remote working if we consider that safeguarding controls provide insufficient protection. We might suggest a salaried/educational minimum to avoid it becoming a pay to work scheme

- **Market impact –** we will need to assess the likely impact of the scheme on the market and the development of the workforce. We may need to contend with competition from other quality assurance schemes. We may impact on the voluntary sector either diminishing the supply through prohibitive costs or causing them to alter their service or description of services. Alternatively, this might offer an appropriate means of protecting the public if voluntary provision is seen as a way of circumventing necessary standards.

- Entry to the scheme might alter market competiveness. We will need to consider whether to permit multiple voluntary registers servicing the same occupational groups or limit admissions. Some disciplines currently have a number of voluntary register groups who compete for members.

- **Compliance –** our primary means of encouraging compliance with our scheme will be though positive influence. Ultimately we will be able to expel a non-compliant group and place that information in the public domain. Member groups can similarly strike members of their registers but this does not prevent members from working. Member groups should agree not to admit individuals who have been struck off by another member, in

accordance with defined criteria that seek to balance the rights of the individual, free trade and protection of the public.

- **Public awareness –** the scheme will need to be promoted effectively to the public in order to raise awareness. The messages are complex and will require careful explanation. We might develop a common portal for searching registers to provide the public with a one stop professional 'shop'. It may be beneficial to develop a symbology - an at-a-glance visual typology to help the public easily distinguish the groups, the type of service offered and the evidential basis for their claims to efficacy.

- CHRE would need to consider the extent to which it will independently engage with the public to receive and respond to feedback. It might include an open access section on its website to allow the public to post feedback. Alternatively, it might require its members to maintain such a site. Encouraging engagement with the public will necessarily attract costs in servicing a site.

- **Standards -** the scheme will potentially span a wide variety of occupational groups. It might aim to use generic standards for entry with the option of additional profession or category (see above) specific criteria where we consider it appropriate. The different characteristics of the groups who are potentially attracted to the scheme means that it may be necessary to classify them into groups and possibly distinguish them within the scheme.

- **Costs –** many voluntary registers are managed by practitioners who take up voluntary positions to operate the register and cannot afford to employ staff. The scheme must therefore be commensurate with voluntary resources and with the different budgets of the groups. This will affect the amounts that CHRE can charge. An option would be to explore a cost sharing or subsidy model in which higher earning groups pay greater contributions to facilitate the common aim of driving up overall standards of care.

- We will need to balance the costs of operating different quality assurance methods with their benefits. We should consider whether we will give credits for membership of other quality assurance schemes or work in conjunction with them.

7. Next steps

7.1 Subject to legislation, we expect that the reformed and renamed CHRE will become operational in April 2012.

7.2 We will need to work in partnership with those voluntary registers which might seek to be early adopters of the quality assurance scheme. It would be our intention to establish an expert reference group to provide impartial and independent advice to CHRE on the formation of its scheme. We would also establish working groups of voluntary register groups and other interested parties to help us scope and develop proposals. This paper sets out our initial views on designing and operating such a scheme. Following publication of the Bill, there will be ongoing opportunities throughout 2011 to contribute to our work and a formal consultation in the autumn.

7.3 We welcome feedback on our early thoughts by **12 January 2011.**