BY E-MAIL

professional standards authority

Lord Patel
Chair – Long-Term Sustainability of the NHS Committee
c/o Patrick Milner
Clerk to Committee
House of Lords
London
SW1A 0PW

27 September 2016

Dear Lord Patel,

Call for evidence for the Committee on the long-term sustainability of the NHS

I am pleased to have this opportunity to submit evidence to the Committee, on behalf of the Professional Standards Authority, on this important topic. Our role is to oversee the regulation of health professionals in the UK, and social workers in England. We also advise the four UK governments on matters relating to the regulation and registration of health and care occupations.

In 2010, we published *Right-touch regulation* (revised in 2015), which sets out our thinking on how regulatory policy should be developed. It stresses that regulation should be agile and risk-based, and that the minimum regulatory force should be used to address identified risks of harm. It argues that regulation should focus on quality control rather than quality improvement, but that it should help to create an environment in which professionalism can flourish. It aims to prevent the introduction of unnecessary regulatory interventions.

Growing demand is putting unprecedented strain on the health and care system, and provision of care struggles to keep pace with technological improvements. The role of regulation is to provide assurance that care remains safe for patients and service users. Professional regulation specifically ensures that professionals are appropriately qualified and maintain their knowledge and skills over the course of their career and that appropriate action is taken if concerns are raised about their fitness to practise. A criticism that is often levelled at regulation is that it stifles change, improvement and innovation – while do we do not believe this criticism is always justified, the current frameworks in place in the UK may in some circumstances have that effect.

In the last twelve months or so, we have put our minds to the question of how to reform professional regulation in health and care so that it meets current and future needs. The comments in our submission on the following pages draw heavily on one existing paper –

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Rethinking regulation – and one that is soon to be published – *Regulation rethought.*[1] You may wish to refer to these publications for more detail as we have attempted to keep this submission as brief as possible.

I hope you will find our contribution useful. We will forward a copy of *Regulation rethought* to you as soon as it is available. *Rethinking regulation* is attached.

Yours sincerely,

Harry Cayton CBE
Chief Executive

[1] All our publications area available on our website at www.professionalstandards.org.uk.

Written evidence to the House of Lords Select Committee on the long-term sustainability of the NHS

September 2016

1. Workforce

1.1 As we outlined in *Rethinking regulation*,[2] quoting the NHS Institute for Innovation and Improvement as was, the NHS currently faces a number of big challenges, including:

- 'The persistent gap between demand for healthcare and the resources available to meet these
- The need to move from a 'sickness' to a 'health' service
- Disparities in health profiles and outcomes for different geographical and social groups
- The co-existence of 'collaboration' and 'competition' in policy prescriptions and institutional arrangements
- The increasing demands placed on services by patterns of health and ill health, notably resulting from an ageing society
- The need to increase accountability to the public
- A workforce that are 'battle weary' following successive structural reforms.'[3]

1.2 We also evoked the challenges presented by 'further changes in professional roles and boundaries, the introduction of new technologies and innovative treatments, a shift to more care being delivered at home, and increasingly shared responsibility for the delivery of care from individuals to teams'. The theme of integrating health and social care was of course also central to our thinking.

1.3 The prospect of the UK withdrawing from the EU further complicates the picture, as providers face the prospect of a possible reduction in the numbers of staff recruited from other EU/EEA countries. Recent figures show that one in ten doctors and one in twenty nurses working in the UK are EU migrants.[4]

1.4 While we may not be able to predict the precise demands on a future workforce in health and social care, we can say with a degree of confidence that the workforce of the future will present the following characteristics:

- Greater reliance on support roles, with the development of new positions, such as the proposed nursing associate role[5] – as a less expensive, more flexible, quicker way of providing care than training, recruiting and employing more senior regulated professionals

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[2] Professional Standards Authority (2015), *Rethinking regulation.* http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf

[3] NHS (2013) *An introduction to public value*

[4] See Annex A for a breakdown of numbers of EU/EEA-qualified registrants by regulator.

[5] See: https://hee.nhs.uk/our-work/developing-our-workforce/nursing/new-support-role-nursing

- Increased flexibility and fluidity between roles and across disciplines – to accommodate the new ways in which care will be delivered in terms of both emerging technologies, and evolving care needs
- More professionals and practitioners providing community-based care, particularly in people's homes – to ease provision in hospitals, and provide a more sustainable way of caring for people with long-term conditions.

1.5 We also hope to see an increased use of the practitioners providing alternative or complementary care that are on our accredited registers.[6] This is a workforce of approximately 71,900 practitioners, covering 54 occupations, from counselling and psychotherapy to foot care and acupuncture. These organisations gain accreditation from us if they meet our standards for how to run a register in the public interest. This workforce has huge, as yet mostly untapped, potential for easing the pressure on NHS services and reducing the demands placed on regulated professionals.

2. Reforming regulation for the future

2.1 A number of risks and challenges emerge from the changes described in the previous section. We do not believe that regulation could or should bear sole responsibility for mitigating any increases in risks that arise as the health and care service struggles to adapt to new pressures and circumstances. As we outlined in *Right-touch regulation*,[7] the responsibility for providing safe care and mitigating risks of harm to patients and service users lies first and foremost with professionals, providers, commissioners, and employers. Regulatory interventions should be considered a last resort. However, regulators and governments do have a responsibility to respond to new and emerging risks, and to adapt to ensure that regulation is not a hindrance to innovation and change: agility is key.

2.2 If in the future, there is greater reliance on support roles, the public, employers, and other health and care professionals will need assurance that the risks presented by these roles have been assessed and are being appropriately addressed. We have developed a methodology for assessing the risks of an occupation or profession, and for identifying appropriate means of assurance to address those risks. The application of this methodology could over time bring some consistency to decisions about how or whether to regulate different groups. It could also encourage the use of alternatives to statutory regulation, such as accredited registers, [8] credentialing,[9] or employer-led codes of practice.[10] These non-statutory options usually have the advantage of being less expensive and quicker to implement, and can be more responsive to change.

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[6] See: http://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register
[7] Professional Standards Authority (2015), *Right-touch regulation – Revised*. http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf
[8] See: http://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register
[9] See for example: https://www.networks.nhs.uk/nhs-networks/credentialling-for-the-life-sciences-industry/news/june-2015-credentialing-project-update
[10] See for example: http://www.hcswtoolkit.nes.scot.nhs.uk/resources/hcsw-standards-and-codes/

2.3 In order for there to be some fluidity in the boundaries between roles, regulation will need to adapt so that it is not continuing to set or enforce boundaries that are no longer useful or relevant. In our forthcoming publication *Regulation rethought*,[11] we propose that greater cost-effectiveness and efficiency might be achieved through the merging of regulators. Larger regulators could in future help to remove some of the barriers between professions, and allow for greater fluidity and overlap in scopes of practice, if the need arose.

2.4 We also suggest in *Regulation rethought* that the regulators work towards establishing a shared public register to encompass, in time, not only regulated professionals, but also those on accredited registers and other currently unregistered occupations, subject to proper risk profiling. The aim is to create a more agile framework that is easier for the public, employers, and professionals themselves to navigate. It would facilitate the use of alternatives to statutory regulation that provide greater flexibility to accommodate evolving role boundaries. In addition, the imposition of a shared code of practice for all those on the register would help to instil a shared sense of purpose and belonging across all registered health and care occupations – thereby helping to break down cultural barriers between groups.

2.5 Our proposal for a single register could help to address some of the risks presented by an increase in provision of care in people's homes. Much of this care is likely to be provided by low-paid support workers in a relatively transient workforce. For these groups, the option of statutory regulation may not be viable. However, the domiciliary care setting might suggest a need for a public register through which employers or service users themselves could check an individual's identity, suitability to practise, and relevant employment history. Our proposals could provide this.

2.6 Finally, in writing *Regulation rethought*, we were acutely aware of the cost of running the current regulatory framework – costs that are passed on to health and care professionals themselves.[12] Several of our proposals, not just the merger of regulators, but also recommendations for example around reform of their complaints functions, could help to reduce the financial impact of regulation on the health and care system as a whole.

3. In conclusion

3.1 As we made clear in *Rethinking regulation*, the current regulatory framework is not fit for purpose. It is based largely on the model of self-regulation that was created for doctors 150 years ago, that has now been adopted across the eight other statutory regulators. It is out-dated, inflexible, and expensive. The regulatory functions are enshrined in nine separate pieces of primary legislation – one for each regulator – which makes reforming the system as a whole a complex, highly technical task that so far no Government has tackled.

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[11] This paper will be available at www.professionalstandards.org.uk once published.

[12] In *Rethinking regulation*, we quoted the figure of £195 million for the combined total annual operating costs of the nine regulators we oversee. This was calculated by the Centre for Health Service Economics and Organisation for the financial year 2010-2011.

3.2 There was widespread disappointment that the reforms proposed by Law Commissions in 2014[13] were not taken forward under the Coalition Government. The current Government is however committed to reforming the system as a whole, with a focus on 'better regulation, autonomy and cost-effectiveness'.[14] They intend to base their reforms both on the Law Commissions' work, and on our paper, *Rethinking regulation*. We hope that these necessary reforms will be brought forward and believe that they could help to address some of the issues of sustainability highlighted in this paper.

Professional Standards Authority for Health and Social Care
27 September 2016

[13] See: http://www.lawcom.gov.uk/project/regulation-of-health-and-social-care-professionals/
[14] See Ben Gummer MP's written ministerial statement: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Lords/2015-12-17/HLWS421/

Annex A: Percentage of EU/EEA registrants on UK registers

3.3 The table below shows the total number of registrants broken down by UK, EU/EEA and non-EU/EAA graduates (figures for the final quarter of 2015/16).[15]

Nursing and Midwifery Council	UK graduates: 589,197 **EU/EAA graduate: 34,391 (5%)** Non-EU/EAA graduate: 66,876 Total: 690,464
General Dental Council	UK graduate: 96,101 **EU/EEA graduate: 6,838 (just over 6%)** Non-EU/EAA graduate: 4,891 Total: 107,830
General Medical Council	UK graduate: 173,316 **EU/EEA graduate: 30,079 (just over 10%)** Non- EU/EAA graduate: 70,408 Total: 273,803
General Chiropractic Council	UK graduate: 2,731 **EU/EEA graduate: 20** Non-EU/EAA graduate: 393 Total: 3,144
General Optical Council	UK graduate: 20,877 **EU/EAA graduate: 230** Non-EU/EAA graduate: 86 Bodies corporate: 2,526 Total: 23,719 (inc. bodies corp) 21,193 (ex. Bodies corp)
General Osteopathic Council	UK graduate: 5,074 **EU/EAA graduate: 24** Non-EU/EAA graduate 15 Total: 5,113
General Pharmaceutical Council	UK graduate: 68,034 **EU/EAA graduate: 3,554** Non-EU/EAA graduate: 2,846 Unknown graduate: 523 Premises: 14,393 Total: 89,350
Health and Care Professions Council	341,745 (not broken down on register)
Pharmaceutical Society of Northern Ireland	UK graduate: 2,309 **EU/EAA graduate: 2** Non-EU/EAA graduate: 0 Premises: 550 Total: 2,861

[15] Figures provided to the Authority by the regulators we oversee, as part of the quarterly data collection for our Performance Review.