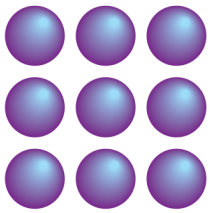
Distributed Regulation

A call for information

January 2010



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Introduction

There are circumstances where health professionals extend their scope of practice to an area where the standards are set by another regulator or professional body. We are seeking responses to this paper to understand what public protection issues might arise from these situations.

An example might be a podiatrist moving into surgical podiatry, or a nurse becoming a surgical practitioner. In these examples, the health professional would originally be registered with the HPC or the NMC respectively, but the new roles require certain skills which those regulators do not traditionally set standards for. Health professionals may expect to be registered by two regulators in these circumstances.

The Secretary of State for Health has asked CHRE[1] to provide advice and recommendations on how regulators might respond in these circumstances. In particular, we have been asked to look at a proposed model currently referred to as 'distributed regulation'.

A model of 'distributed regulation' may mean that the primary regulator would continue to register the professional, but could seek advice from a relevant professional body to determine the standards which should be adhered to. Once these standards had been met, the register entry could be annotated accordingly.

It has been suggested that the advantage of this model would be to provide a more coordinated approach to regulation and to reduce the cost and burden of professionals being registered with two different regulators. Potential disadvantages include adding a further layer of complexity to the regulation of health professionals, and making it less obvious which regulator the public should contact if there is reason to make a complaint.

We are seeking responses to the questions raised on page five of this paper by 15 February 2010.

We are approaching this work from the perspective of ensuring effective regulation to enhance public protection. This work will not make any judgments on whether it is appropriate for certain health professionals to undertake certain areas of practice.

1 The Council for Healthcare Regulatory Excellence (CHRE) oversees the General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI), Royal Pharmaceutical Society of Great Britain (RPSGB)

Background

1.1 The concept of 'distributed regulation' was first discussed in *The regulation of the non-medical healthcare professions*[2] in 2006. The report recommends the statutory regulation of several new roles, including surgical care practitioners and emergency care practitioners. It recommends that a system of 'distributed regulation' should be established to enable these professionals to remain with their existing regulator, rather than give up their existing registration or hold dual registration. The concept of 'distributed regulation' was then built upon in several further documents,[3] to describe a wider range of circumstances where it might be appropriate.

Regulatory options

1.2 We understand that there are broadly three situations where a health professional's practice might mean they are associated with more than one regulator:

- ***Scenario 1:*** Where a health professional is qualified to practise in two distinct areas. For example, a chiropractor/osteopath, a doctor/dentist or a nurse/physiotherapist
- ***Scenario 2:*** Where a health professional has widened their scope of practice to include a more specialised area. For example, a podiatrist wishing to undertake surgical procedures, or a nurse taking on endoscopic procedures
- ***Scenario 3:*** Where an individual enters the health profession directly into one of the new roles defined in *The regulation of the non-medical healthcare professions*.

1.3 The evidence to date is unclear as to whether the example described in Scenario 3 is currently applicable to any professionals. The situation most commonly referred to is Scenario 2, and the example of podiatric surgeons is described in more detail below. The circumstances described Scenario 1 remain relevant, but this may indicate a desire from the professional to retain dual registration for the purpose of their own practice.

1.4 We do not have detailed figures on how many professionals fall within the scenarios described above. However the figures below provide a useful guide:

- There are approximately 160 podiatric surgeons in the UK[4]
- There are approximately 690 emergency care practitioners in England[5]
- There are over 400 surgical care practitioners in the UK.[6]

2 Department of Health (2006). *The regulation of the non-medical healthcare professions*.
3 *Trust, Assurance and Safety* (Department of Health 2007), *Distributed regulation model – discussion paper* (Scottish Government Health Directorates, 2008), *Extending professional and occupational regulation* (Extending Professional Regulation Working Group, 2009)
4 Source: The Society of Chiropodists and Podiatrists
5 Source: The NHS Information Centre
6 Source: The National Association of Assistants in Surgical Practice

Podiatric surgeons

A working model for 'distributed regulation' has been suggested to us for podiatric surgeons:

Under the proposed system, a podiatrist registered with the HPC wishing to undertake podiatric surgery would adhere to training and practice standards set in conjunction with the Faculty of Podiatric Surgery and the GMC. The practitioner would remain registered with the HPC, but their register entry would be annotated once the required standards had been met. The HPC would investigate any fitness to practise issues, but might need to give due regard to professional advice and assistance from the GMC and the Faculty, if the matter involved the practitioner's surgical practice.

Advanced and specialist practice

1.5 In July 2009 we produced a report on Advanced Practice,[7] which looked at the issues that can arise when health professionals take on responsibilities not traditionally associated with their professions. Based on the evidence we concluded that much of what is called 'advanced practice' reflects career development and does not warrant additional statutory regulation. However the report went on to say:

If an area of practice within a profession develops which poses different types of risk to patients and requires new standards of proficiency to be performed safely, which are clearly distinct from the range of those ordinarily associated with the profession, regulatory bodies need to ensure their processes capture this.

1.6 Regulatory bodies must have good links with employers and professional bodies to identify potential risks to public protection and ensure that any regulatory action is targeted and proportionate.

1.7 It is a general principle of public law that a body's statutory powers are not delegated to another legal authority (though there are exceptions to this). However it is possible that delegation could be avoided through consultation between parties, and by setting up joint working parties or committees to set appropriate standards, for example.

1.8 The regulators make annotations on the register to indicate where a professional has undertaken a post-registration qualification and/or acquired additional skills and competence. This can be presented as specialist lists, as held by the GMC and GDC, or as annotations on the register, as in the case of PSNI and RPSGB, for example.

7 CHRE (2009). *Advanced Practice*. Available at http://www.chre.org.uk/satellite/116/

Fitness to practise

1.9 One of CHRE's roles is to review fitness to practise decisions made by the regulators' committees and panels. We can refer such decisions to court if we consider that they are unduly lenient.

1.10 In one example, we referred a case where a professional was registered with two regulators. Following allegations of inappropriate behaviour and inadequate practice, the professional was managed through fitness to practise procedures by both regulators. From one regulator, the professional received conditions of practice for six months, from the other regulator the professional was struck off the register.

1.11 'Distributed regulation' may present an opportunity for the regulators to agree a common set of conduct standards, and potentially tackle the 'double jeopardy' situation described above. This would raise questions about, for instance, whether a general practitioner should be dealt with in the same way as a biomedical scientist for a civil conduct issue, such as a public order offence.

1.12 We believe it would be possible for a regulator to take fitness to practise proceedings against practitioners who fall short of standards set by another body. We note that the GOC 'can take action if a registrant's fitness to practise may be impaired due to… finding of impaired fitness to practise by another regulatory body'.[8]

Possible advantages and disadvantages of 'distributed regulation'

Advantages

- It could enable comparable conduct standards to be developed across the health professions
- Cases of double jeopardy, as described above, could be prevented
- It would represent a more coordinated approach to the regulation of health professionals
- Registration would only be required with one regulator, reducing the cost and burden of regulation.

Disadvantages

- A person wishing to raise a concern about a professional may be confused about which regulator to contact
- It could harm public confidence if two practitioners in the same role are registered by two different regulators, who in turn handle fitness to practise issues differently
- Can a regulator fully understand the competencies of a role that is traditionally overseen by another regulator?
- Adds a further layer of complexity to the regulation of health professionals.

8 Taken from the GOC website.

Discussion and questions

1.13 It is unclear what evidence exists to suggest the public are at risk under the current model of regulation. We are seeking views on whether there is a problem with how practitioners who have widened their practice are currently regulated, and whether public protection would be enhanced by a new regulatory model. If a new system was to be introduced, would it be in the proposed model of 'distributed regulation' outlined above, or as annotations on existing registers or the creation of specialist lists, or a combination of all three? What would we need to consider before introducing such a system?

1.14 There are a number of other issues that are worth considering:

- ***Revalidation:*** Revalidation is the periodic check of health professionals' fitness for practise. When revalidation is introduced, it will place a greater emphasis on regulators to assess developments of an individual's practice. How will this be managed under a system of 'distributed regulation'?
- ***Regulatory structure:*** The GMC describes a four-layer model of regulation which operates at the personal, team, workplace and national level. What considerations might we give to health professionals who are not regularly supervised?
- ***Drawing boundaries:*** For example, how many minor surgical procedures might a nurse undertake before being brought under the proposed model?

Questions to respond to:

1. Is there a public protection issue, or any other issues, with the current system of dual registration? Do you have any evidence of this?
2. Do you support the proposed model of 'distributed regulation' as described above, or can you describe an alternative model?
3. Could there be a common set of conduct standards agreed across the regulators?
4. How would we identify those practitioners who would need to be regulated in this way?

Please send your response by 15 February 2010 to:

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