

# Proposals for CHRE's new roles and responsibilities

October 2010

## 1. Background; government intentions

- 1.1 In the White Paper *Equity and Excellence: Liberating the NHS* (July 2010) the Government set out its plans for the NHS in England. These confirm a move away from a top-down managed healthcare system towards a more regulated local healthcare market. The White Paper says that 'autonomy in commissioning will be matched by autonomy for providers' and that 'our ambition is to create the largest and most vibrant social enterprise sector in the world.' Further, that 'providers will no longer be part of a system of top-down management subject to political interference. Instead they will be governed by a stable, transparent and rule based system of regulation'.
- 1.2 The Department of Health's Review of Arm's-Length Bodies stated that CHRE would become 'self-funding through a levy on those it regulates' and that our remit would be extended 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. Provision for these changes will be made in forthcoming legislation. Details of these new arrangements have been discussed within CHRE and with colleagues in the Department of Health over the summer. The reforms are therefore still subject to government decisions, legislation and parliamentary approval.
- 1.3 This paper sets out our understanding of the roles and responsibilities that the Government intends us to have in the future and describes, in outline, how we expect to operate and the powers we will need to do so effectively.
- 1.4 We are submitting this paper to the Department of Health in England and to the health departments in Scotland, Wales and Northern Ireland. We hope our views on how the Government's intentions can be put into practice will be helpful. We are also distributing this paper to our partner organisations to seek their comments if any. There will be formal consultation on some matters in due course, subject to parliamentary approval of changes.

## 2. New roles for reformed and renamed CHRE

### *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 would be 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. 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 The purpose of the voluntary scheme will be to encourage the development of professional conduct, ethical practice and high standards of performance in groups associated with or affiliated to the delivery of health and social care, where statutory regulation is not necessary to protect the public.
- 2.4 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 who have or wish to establish their own registers of members. We will admit groups to the scheme and will approve their Codes and governance arrangements. Groups may commission us to review their governance arrangements as required. We will periodically review organisational compliance. We will ensure that such arrangements are agile, coherent and underpin joint working across health and social care.
- 2.5 A number of existing occupational 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.
- 2.6 If approved by Parliament, we intend to publicise the forthcoming quality assurance scheme on our website in 2011 and to work with aspirant groups, to encourage their preparation for registration from April 2012 onwards.

### ***Movement between statutory regulation and voluntary registration***

- 2.7 We think it would be helpful for CHRE to be given the discretionary power to recommend a group for statutory regulation in the interests of public protection in order to respond to changing patterns of healthcare delivery which may give rise, in future, to new or different areas of risk. This would ensure that public protection was achieved in the most proportionate and cost effective manner.
- 2.8 It is also possible that CHRE might recommend that a particular group ceased to be regulated and became voluntarily registered instead. Deregulation is an important component in a system that is able to respond to change and to use a right-touch approach. Deregulation clearly needs to be risk based but becomes an option where a quality assured alternative to statutory regulation exists. This would therefore be one of the benefits of a new system.
- 2.9 Other regulatory solutions are also possible such as licensing or employer-led codes of practice. It will be appropriate in certain circumstances for CHRE to recommend these approaches for particular groups.

### *Extension of CHRE's role to cover social work*

- 2.10 The Government intends to transfer the regulation of social workers from the General Social Care Council (GSCC) to the (renamed) HPC. We already have experience of social work regulation through our collaborative relationship with the GSCC. The absorption of the GSCC's cases into the HPC will mean an increase in the number of cases we review under s29, as well as an increase in our scrutiny and audit work, particularly initially, to ensure that the transfer of regulatory functions has maintained protection of the public. We hope that our existing resources will be sufficient to absorb this additional workload, provided that we make some internal changes to free capacity, but will keep that under review. In the mean time we will work with the HPC and GSCC to support them in an effective transfer of the register and the regulation of social workers.

### *Administrative complaints function for CHRE*

- 2.11 Section 28 of the National Health Services Reform and Health Professionals Act 2002 provides a power for CHRE to consider complaints against the regulators but the necessary regulations have not been enacted. However we have worked with the regulators on a voluntary basis over the last three years in relation to those complaints that are made to us. We have concluded that there is little benefit for patients or the public in CHRE having the power to investigate individual complaints about the regulators, as we would be unable to change decisions or provide redress. It would benefit the public however if we were able to investigate and report on complaints of maladministration. These would be rare complaints where failure by a regulator to follow its practice or procedures seems so serious as to have put the public at risk, or to result in a regulator's failure to fulfil its statutory duties. Dealing with such complaints would also provide information that might be useful to CHRE in targeting its annual reviews of the regulators at areas of greatest risk, and might even trigger an interim targeted assessment in serious cases. The Department of Health has asked us to submit a proposal for the enactment of s28 of our legislation to bring this about.
- 2.12 CHRE already has power under s27(2) of its legislation to direct a regulator to change its rules. Such a direction might be made in circumstances of maladministration or failure by a regulator to fulfil a statutory function. An improvement on the current wording of s27(2) might be for CHRE to be given the power to report to the Privy Council, that it had, in its view, identified significant failings, and make particular recommendations for their remedy. This leaves ultimate accountability with Parliament, via the Privy Council. Such a power of last resort would follow on logically from the power to investigate complaints of maladministration.

### *Supporting the quality of appointments to regulators' councils*

- 2.13 With the abolition of the NHS Appointments Commission, the Government is considering giving the reformed CHRE a role in overseeing the process of appointments to the councils of the regulators. We would have a conflict of interest if we made the appointments ourselves should we subsequently criticise the performance of a particular council. We propose that CHRE agrees standards for recruitment and appointment with the regulators and reviews in any particular case

that the standards have been adhered to and that the person the regulator proposes to appoint meets the person specification. We would then inform the Privy Council that the process complied with the standards and the Privy Council would confirm the appointment. Regulators would be responsible for managing their own appointments.

### **3. UK-wide regulation; working with all four governments**

- 3.1 Most, but not all, health professional regulation is on a UK-wide basis. The regulation of social work is devolved, as will be new provisions for health professional regulation. Different approaches are also developing in relation to health or social care support workers and in relation to the regulatory aspects of safeguarding. Some voluntary occupational registers draw members from across the UK, others do not.
- 3.2 As a UK-wide body, we will continue to contribute constructively to improving regulation across all four countries where we have a statutory role, and to work collaboratively and by invitation where we do not.
- 3.3 We hope that our Board will continue to draw on relevant expertise from all parts of the UK, and that provision can be made in our legislation to enable this.
- 3.4 Appropriate legal arrangements will need to be in place to enable payment of the funding levy by the Pharmaceutical Society of Northern Ireland. We have raised this with the Department for Health, Social Services and Public Safety, Northern Ireland.

### **4. Business model and funding arrangements**

- 4.1 The reformed and renamed CHRE will be a public body with statutory duties and will be accountable to Parliament through the Privy Council. It will not be a Departmental Arm's-Length Body. The reformed CHRE will be subject to scrutiny by the National Audit Office and will still present its annual accounts to Parliament.
- 4.2 The reformed CHRE will have an appointed Board of a similar size to the current Council. Since the intention is to reform the CHRE, the existing Council will continue in post during the transition.
- 4.3 CHRE will be financed through a levy on the regulatory bodies that it oversees. It will also be able to generate income from other activities, such as the quality assurance of voluntary registers. It is anticipated that the latter will be on a cost-recovery basis. The legislation should enable the reformed CHRE to make and keep income, for example, fees for performance reviews of overseas regulators, or subscriptions to the International Observatory.
- 4.4 The Government's intention is that all the CHRE work, including policy and practice development, will be within the new statutory duties and will be funded through the levy. The legislation will be drafted to ensure that such work is clearly included within the regulatory scheme. The expectation is that the levy will be collected annually from each of the regulators. It will be for them to determine how they collect it from their registrants.
- 4.5 In addition we expect the four governments in the UK to commission, jointly or separately, policy work and to pay for this if the cost is over and above the scope of resources available to us through the levy.

- 4.6 We propose that the levy will be a *per capita* sum based on the number of registrants registered on a given date. Subject to approval of this principle by the Government, we will discuss with the regulators if this should be a straight *per capita* arrangement, or if it should be modified to include a minimum and a maximum total to be paid. There will be consultation on the mechanism for and calculation of the levy in due course.
- 4.7 The income from the levy may well not be collected until after the beginning of the financial year. Accordingly, the reformed CHRE will inevitably need funding, especially in the first year, that it can draw upon in the interim. This will be addressed through the legislative framework and the transitional arrangements. We have asked for a power to borrow and also to receive loans from the Government.

## 5. New name and legal changes

- 5.1 Legislation will be needed to bring about most, but not all, of the changes proposed for CHRE; the change to our funding arrangements, change to our statutory accountability, change to our role in relation to voluntary registers, change to our name. The possible implementation of s28 of our existing legislation to enable us to investigate complaints against the regulators in circumstances where we believe maladministration has taken place can be brought about through regulations.
- 5.2 The Department of Health has told us that it is their intention to maintain the current Board membership and organisational entity through the transition. We will not be closing down and opening up again as a new body, but continuing with a change of name, roles and financial powers. Council members will become members of the Board of the reformed CHRE. Staff members will have continuity of employment.
- 5.3 We have given considerable thought to the change of name. Our primary intention is to have a name which reflects our range of roles and purpose, is readily understood, easy to say, and avoids unhelpful acronyms.
- 5.4 We are not ourselves a regulator, and in our extended role in quality assuring voluntary registers will move beyond overseeing regulation. The common aspect of our oversight of both statutory regulation and voluntary registers is the improvement of standards. We also note that CHRE is intended to be 'an authoritative voice for patients and other members of the public in the regulation of (health) professionals.'<sup>1</sup> CHRE is no longer a 'council' of the regulators. We also consider a clear change of name will signal a new identity.
- 5.5 We therefore propose the following alternatives:
- *The Professional Standards Authority for Health & Social Care*  
or  
*The Office for Professional Standards in Health & Social Care*
  - *The Regulation Authority for Health & Social Care Professionals*  
or  
*The Office for Care Regulation*

---

<sup>1</sup> *Trust Assurance and Safety: the Regulation of Health Professionals in the 21<sup>st</sup> Century* TSO, 2007

- 5.6 We invite our partners to comment on these possible names and to let us have their views on them.

## **6. Transitional arrangements and risk management**

- 6.1 Subject to legislation, we expect that the reformed and renamed CHRE will become operational in April 2012.
- 6.2 There will however be a considerable amount of work to be undertaken to get to that point. This will need to be undertaken alongside the work necessary for the CHRE to fulfil its ongoing statutory duties.
- 6.3 To ensure a smooth transition there will need to be a phased development and introduction of work that will support the change-over. Any new staff that will need to be in place by April 2012 will need to have been recruited and trained in advance.
- 6.4 We will need to work in partnership with the regulators prior to April 2012 in particular in developing standards for recruitment to their councils.
- 6.5 We will also work with those voluntary registers which might seek to join the quality assurance scheme.
- 6.6 The reformed CHRE will be funded through the levy, subscriptions and other sources, which will involve significant changes to the financial arrangements and could put pressure on the new organisation's cash-flow, especially in the first year of operation. There will also be a need for contracts to be reviewed and re-signed, and for policy and guidance documents (especially those relating to corporate governance) to be reviewed and updated.
- 6.7 It is expected that the founding legislation will facilitate the payment of either a transitional loan from Treasury (repayable when the levy income is received) or a degree of initial stakeholder funding from Treasury which would be repayable in the event of the body being wound up.
- 6.8 We have identified risks to the success of the new organisation and where possible these have been raised with the Department of Health, with a view to mitigating them through the legislative framework.
- 6.9 Further work will be undertaken by CHRE's Senior Management Team to identify the risks that may occur during 2010/2012 as the new organisation is developed and made operational. The fact that we are small is an inherent risk, given that the workload and range of tasks that will need to be addressed in the coming months will increase, while the work to fulfil the current statutory duties will not diminish.