

(updated following meeting of 22nd October 2007)

PROGRAMME INITIATION DOCUMENT (PID) – “Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century” Implementation in Scotland

1.	<p>PURPOSE <i>The purpose of this programme of work is to effectively implement within Scotland the UK policies set out in the UK Government White paper on regulation of the health professions, taking account of the differing needs of, and structures, services and agencies within, a devolved health service in Scotland.</i></p>	
2.	<p>BACKGROUND AND CONTEXT</p>	<p>2.1 Between 1972 and 1998, It is estimated that Dr Harold Shipman was responsible for in excess of 200 of his patients’ deaths. He was convicted on 31 January 2000 and was also found guilty of forging the will of his final victim.</p> <p>2.2 In January 2001 an inquiry began, chaired by Dame Janet Smith. This led to the publication of six inquiry reports; the first report was “Death Disguised” (2002). It is thought that Shipman could have been responsible for up to 215 deaths.</p> <p>2.3 Other less well known cases such as the Ayling, Haslam, Kerr and Neale enquiries raised similar issues to those of the Shipman case, such as the failure to investigate serious allegations, the need for precaution in relation to vulnerable patients and ensuring clear boundaries between doctors and patients.</p> <p>2.4 In the fifth Shipman inquiry report “Safeguarding Patients: Lessons from the past – Proposals for the Future” (2004), numerous concerns were expressed regarding the General Medical Council (GMC), in relation to its structure and functions, but in particular to its proposed system for revalidation which was perceived as ‘inadequate’. As a result, Ministers asked Sir Liam Donaldson, Chief Medical Officer for England, to review the arrangements in place to protect patients from harm caused by the poor performance of doctors. Dr John Reid, the then Secretary of State for Health, also announces a parallel Department of Health (England) (DH) review to examine arrangements in place for the regulation of the other healthcare professions. This review was led by Andrew Foster, then Director General of Workforce at DH.</p> <p>2.5 The aim of undertaking both reviews at the same time was to ensure the development of a coherent approach to regulation across all health professions.</p>

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		<p>2.6 Between July and November 2006, public consultation took place on <i>Good doctors, safer patients</i> – a report submitted to Ministers for publication by Sir Liam Donaldson in his independent capacity as Chief Medical Officer for England and chief medical advisor to the UK Government – as well as on <i>The regulation of the non-medical healthcare professions</i> – a Department of Health report intended and phrased for consultation.</p> <p>2.7 On 21 February 2007 a UK Government White Paper <i>Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century</i> was published. The policy intentions, once implemented, set out to “provide for safer patient care in the UK and will enable the public and patients to be confident that the health professional who cares for them is practising to nationally agreed standards based on an ethos of high quality care”¹.”</p> <p>2.8 The White Paper sets the context for this project initiation document [a pdf copy of the White paper will be available].</p>
3.	OBJECTIVE/S	<p>The objectives for this programme of work reflect the need to consider, according to Scotland’s specific needs, the necessary actions for the implementation of policies stated in the UK White Paper. These cover both reserved and devolved areas and are detailed, together with identified Scottish Government Health Directorates (SGHD) policy leads, in Annex A to this PID.</p> <p>Strategic Aim:</p> <p>3.1 To improve the quality and safety of healthcare delivery in Scotland</p> <p>Specific governing objectives to:</p> <p>3.2 Promote and assure the good practice of health professionals in Scotland.</p> <p>3.3 Increase Scottish public and professional confidence in the UK regulators and their procedures.</p> <p>3.4 Enhance closer working between the UK regulators and those in Scotland who employ or contract with the professions.</p> <p>3.5 Develop a cohesive framework in Scotland in order that policy intentions within the UK</p>

¹ DH (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* p 21. A Government White Paper. DH England.

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		<p>Government White Paper are implemented in Scotland as appropriate and according to need.</p>
<p>4.</p>	<p>IMPACT</p>	<p>It is anticipated that implementation of the White Paper in Scotland will have the following impact:</p> <p>4.1 The commitment of the Devolved Administration in Scotland to UK wide regulation will continue. 4.2 Some of the White Paper proposals will require to be adapted in order to work well in Scotland; both for devolved (where considered necessary) and reserved areas. 4.3 The different structures, systems, processes and accountability mechanisms in Scotland will be taken account of in terms of operational practicalities. 4.4 Health professionals will be able to move easily around the UK. 4.5 There will be a clear focus on patient safety. 4.6 There will be improvement in the delivery of healthcare. 4.7 There will be a focus on over-arching consumer principles and consumer outcomes in order to improve public confidence, deliver better healthcare and ensure consistency of standards. 4.8 There will be increased public involvement through the lay majority composition of Councils 4.9 Health professionals and employers in Scotland will have confidence in the statutory regulators. 4.10 The measures to implement the regulation in the Independent sector in Scotland will be assessed. 4.11 Public confidence in health professionals will be raised.</p>
<p>5.</p>	<p>ISSUES AND ASSUMPTIONS (Risks, Exclusions and Constraints)</p>	<p>Challenges</p> <p>5.1 The regulation of new health professions after the Scotland Act in 1998 is devolved to the Scottish Parliament. The delivery of NHS services and their structures are also devolved matters. The White Paper proposes changes to both devolved and reserved areas. This presents challenges in terms of putting in place as early as possible the legislative and practical arrangements which will make these changes across the UK. A UK Bill and a series of Section 60 Orders will be taken forward as soon as possible.</p> <p>Budget</p> <p>5.2 To date, DH in England have produced their partial regulatory impact assessment. This contains projected costs of implementation for England, including those impacting on the Independent sector. Much of the detail on costs for Scotland is likely to fall out of the working groups planned.</p> <p>Resources</p>

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		<p>5.3 It is clear that implementing the proposals in Scotland will have significant human resource implications, both internally to SGHD and externally across NHSScotland. Setting up and implementing programme management arrangements, the steering group and implementation groups will impact. Time involved in travelling to London or Leeds to participate in UK wide working groups will also be a regular feature for SGHD and external stakeholder representatives. Added to this will be the requirement to travel throughout Scotland and other parts of the UK, such as Wales and Northern Ireland. The duration of the process of implementation, both in Scotland and across the UK, is difficult to assess exactly at this initial stage but is likely to run until 2011 and will have resource implications throughout.</p> <p>Scope</p> <p>5.4 The scope of the project is Scotland wide with close negotiation necessary with DH England and the other two devolved administrations.</p> <p>Risks</p> <p>5.5 Financial</p> <p>Proportionate costs have been estimated for Scotland in devolved areas, however, it has always been recognised that the different structures and systems here will often necessitate a slightly different route, with cost implications.</p> <p>5.6 Legislative</p> <p>Careful planning will be required to ensure the co-ordination of legislation through both the UK and Scottish Parliaments in areas which are devolved. Delays in either Parliament could result in provisions not being in place at the same time across the UK.</p> <p>-</p> <p>5.7 Timescale</p> <p>The legislative timetable is very tight with DH leading on the drafting of the UK Health and Social Care Bill. This presents a risk in terms of Scottish input to UK wide legislation and identification of the consequential need for any Scottish legislation...</p> <p>DH Working Groups have very challenging timescales for reporting their conclusions in order to meet</p>
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		<p>legislative timetables. The Scottish Working Groups will face the same challenge,</p> <p>5.8 Implementation Any risk to implementation could be as a result of any currently unidentified resource implications. In addition, SGHD input to DH drafting of legislation relies on timely cooperation on the part of both.</p>
<p>6.</p>	<p>PROGRAMME ORGANISATION</p>	<p>6.1 The sponsoring Director for the programme is Paul Martin, CNO, supported by Dr Harry Burns, CMO, and Dr Aileen Keel, DCMO.</p> <p>6.2 The programme will be managed throughout by a SGHD programme management team led by Audrey Cowie, Professional Adviser – Regulation and Workforce Standards. The team will have responsibility for maintaining an overview of all activities on the part of DH and SGHD relating to implementation of the White Paper.</p> <p>6.3 There will be two short-life implementation groups established in Scotland:</p> <ul style="list-style-type: none"> - the “Cross professional fitness to practice” group, and - the “Extending Professional Regulation” group. <p>6.4 Each of the two groups will advise on the practical implementation in Scotland.</p> <p>6.5 There may also be a requirement for sub-groups emanating from these two groups, to consider specific implementation issues for Scotland or to discuss further profession specific issues.</p> <p>6.6 Where it is practical, the Chairs of the SGHD implementation groups will be members of the corresponding DH Working Groups. Where this is not possible, the SE official attending the DH group will provide feedback directly to the Overarching Steering Group.</p> <p>6.7 An already established “SGHD Regulators’ Liaison Group” will act as a key reference group for the programme with cross membership with the Overarching Implementation Steering Group (see section 7).</p>
<p>7.</p>	<p>PROGRAMME STRUCTURE, GOVERNANCE</p> <p style="text-align: center;">AND</p>	<p><i>See Annex B as a supplement to this section</i></p> <p><u>7.1 SGHD Overarching Implementation Steering Group - remit</u></p>

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<p>ARRANGEMENTS</p>	<ul style="list-style-type: none"> • To steer the implementation of the programme against objectives within the project initiation document. • To approve the setting up of a number of short-life SGHD implementation groups in order to meet the programme objectives. • To receive regular feedback from, and approve the actions of, the implementation groups. Regular Implementation Group progress reports will be sent to the Steering Group. • To communicate progress towards achieving the programme’s objectives with stakeholders across Scotland. • To secure the commitment of stakeholders across Scotland towards implementation. <p><u>7.2 Short-life SGHD implementation groups - remit</u></p> <ul style="list-style-type: none"> • To advise on the practical implications of implementing the White Paper policy intentions in Scotland • To provide regular progress reports to the Overarching Steering Group • To actively support communications with stakeholders across Scotland • To meet the objectives defined within the project documentation for each implementation group. <p><u>7.3 Membership of SGHD Overarching Implementation Steering Group</u></p> <p>Joint Chairs – Paul Martin, Chief Nursing Officer / Harry Burns, Chief Medical Officer</p> <p>Kay Blair – Scottish Consumer Council George Brechin - Chair of Management Steering Group of NHSS Employers Reference Forum Susan Brimelow - Care Commission Harry Cayton - Chief Executive, Council for Healthcare Regulatory Excellence, Catherine Clark - Head of Regulatory Unit, SGHD Audrey Cowie - Professional Adviser – Regulation and Workforce Standards, SGHD Geraldine Doherty - Scottish Social Services Council Dr. Frances Dow - Lay Member Dr. Frances Elliot - Chair of Scottish Association of Medical Directors Kath Fairgrieve - Directors / Leads of Allied Health Professions</p>
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		<p>Michael Fuller - Scottish Workforce & Staff Governance Committee Dr. Aileen Keel- Deputy Chief Medical Officer Alex Killick – Associate Director for Workforce (Workforce Employment and Retention), SGHD Jacqui Lunday - Chief Health Professions Officer (AHPs & Healthcare Scientists), SGHD Andrew Macleod - Healthcare, Policy and Strategy, SGHD Elinor Mitchell – Associate Director for Workforce (Workforce Planning & Development), SGHD Eileen Moir - Chair of NHSS Executive Nurse Directors’ Group Jonathan Pryce – Head of Primary Care Division, SGHD Adam Rennie - Primary and Community Care, SGHD Duncan Rudkin - Chief Executive, General Dental Council Bill Scott - Chief Pharmaceutical Officer, SGHD Finlay Scott - Chief Executive, General Medical Council Marc Seale - Chief Executive, Health Professions Council David Steel - Chief Executive, NHS Quality Improvement Scotland Sally Taber - Independent Health Care Margie Taylor - Chief Dental Officer, SGHD Sarah Thewlis - Chief Executive, Nursing and Midwifery Council John Turner – Associate Director for Workforce (Workforce Modernisation), SGHD Rona Webster - Chair of NHSS Executive HR Directors Group Diane White - Children, Young People and Social Care, SEED Malcolm Wright - Chief Executive, NHS Education for Scotland</p> <p>The following representatives are yet to be secured (as at 26.07.07) Independent Practitioner Lay member who is a current patient Scottish Health Council Scottish Public Services Ombudsman</p> <p><u>7.4 Membership of short-life implementation groups</u> <u>[Yet to be agreed with Chairs of groups]</u></p>
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		<p><u>7.5 Reporting Mechanism of short-life groups</u> Tri-monthly updates to the Overarching Implementation Steering Group. Formal reports at key stages to stakeholders.</p> <p><u>7.6 Membership of SGHD Programme Management Group</u> Professional Adviser - Regulation and Workforce Standards (who will also identify cross-cutting issues through membership of the DH <i>Professional Regulation and Patient Safety Programme Board</i>). Head of Regulatory Unit. Two Policy Officers – Regulatory Unit. Administrator.</p>
8.	COMMUNICATIONS PLANNING	<p>8.1 In the lead up to publication of the White Paper, four Scottish Stakeholder Events were organised for March 2007 in order to share information with interested parties as soon as practical. A further four stakeholder events were held in March 2007 following publication of the White paper in order to share information with as wide a group of Scottish stakeholders as possible (reports from both series of events is available).</p> <p>8.2 During implementation of the White Paper in Scotland, regular updates on project activity and achievements against objectives will be sent to NHSScotland boards, to other stakeholder networks (yet to be defined) and to the “Regulators’ Liaison Group” which will act as a key reference group.</p> <p>8.3 SGHD officials will continue to feed in to the UK wide Professional Regulation and Patient Safety Programme Board and to all new UK wide implementation groups led by DH.</p> <p>8.4 Members of the Project Steering Group and short-life implementation groups will be personally responsible for networking widely to assist communications and to facilitate focus group or ‘piloting’ activity where necessary to test out products and ideas.</p> <p>8.5 Further communication requirements will be guided by Steering, Reference and Implementation Groups concerning priority key achievements.</p>

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9. PROPOSED TIME FRAME

This project time line gives an estimate of the time the project will take to deliver and an overview of the key milestones which can be identified at each stage

Set up SGHD Regulators' Liaison Group	Publication of the White Paper	Identify legislative implications for Scotland and feed in to drafting of UK Government Bill as well as section 60 Orders.	Secure funding for implementation of White Paper	Set up of Programme Steering Group (with cross-membership with the Regulator's Liaison Group)	Set up short-life implementation groups	Steering Group to receive updates from Working Groups four times per year.	Initial S60 Orders to be announced.	Health and Social Care Bill to be introduced in the next session of Parliament.	Further S60 Orders to be announced	Implement proposals across Scotland
January 2007	February 2007	Continuous from February 2007	Continuous from February 2007	July 2007	October 2007	Continuous from October 2007	Autumn 2007	November 2007	From Autumn 2008 -2009	By 2011

Trust, Assurance and Safety – *The Regulation of Health Professionals in the 21st Century***Implementation of the White Paper in Scotland****Policy intentions and associated lead officials**

Subject Heading	White Paper proposal	Action	Lead official/s²
Chapter 1 Assuring Independence.	1.1 Ensure that all Councils become more accountable to Parliament , presenting annual reports to the UK and, for those Councils which regulate professions whose regulation is a devolved matter, Devolved Assembly legislatures;	Government will agree arrangements	DH and Catherine Clark
Chapter 1 Assuring Independence.	1.2 Council members will be appointed independently rather than elected to represent a particular constituency.	The Government will review in 2011 , in the light of experience of working with wholly appointed Councils, whether there would be any advantage in the independent appointment of Chairs.	DH and Catherine Clark

² Please note that only the names of lead officials appear here. Other stakeholders implicated in the policy intention and who may provide additional input / advice are not included. It is expected that workstreams emanating from the SGHD Implementation Groups will address all stakeholder interests as far as is practical.

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Subject Heading	White Paper proposal	Action	Lead official/s ²
<p>Chapter 1 Assuring Independence.</p>	<p>1.3 The Government is convinced that in order to establish and sustain confidence in the independence of the regulators, all Councils should be constituted to ensure that professionals do not form a majority.</p>	<p>The Government will seek to secure the legislative changes required to enable the reconstitution of councils with parity of membership as a minimum. For the General Chiropractic Council, which proposed a lay majority in its consultation response, the Government will put in place the necessary enabling legislation, subject to Parliamentary approval. Those that choose parity will be subject to review in 2011 to consider whether these changes have been sufficient to secure that aim.</p>	<p>DH and Catherine Clark</p>
<p>Chapter 1 Assuring Independence</p>	<p>1.4 The Government believes that all the Councils should move to a more consistent and smaller size that enables them to function more effectively as Boards for their organisations, with a statutory duty to ensure that the interests of all its stakeholders are considered in its deliberations. The Government will therefore remove the provision for “alternate” members of some of the Councils, who act as stand-ins if the member they shadow cannot attend</p>	<p>Government supports GMC proposals and will review in 2011.</p> <p>For the other professional regulators, a working group on governance will consider with relevant stakeholders, including the DAs, similar changes. The Government will then seek the necessary changes to legislation.</p>	<p>DH and Catherine Clark</p>

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Subject Heading	White Paper proposal	Action	Lead official/s ²
Chapter 1 Assuring Independence	1.5 Changes to CHRE to reform membership of the Council, with a smaller more board-like membership appointed by the Appointments Commission against a clear set of criteria. The national regulators will no longer nominate members of the CHRE Council. The Chair of the CHRE will be appointed, rather than elected.	The Government will therefore seek to make the necessary legislative changes	DH and Catherine Clark
Chapter 1 Assuring Independence.	1.6 The establishment of a General Pharmaceutical Council.	A working party will be established to take forward detailed proposals.	DH and Bill Scott, CPO and Catherine Clark
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.1 Revalidation of doctors. All doctors wishing to practise in the UK will require a licence to practise. As a first stage, the GMC will issue these licences to practise as soon as it is practicable to do so.	DH will discuss with stakeholders ways of ensuring that revalidation can be applied appropriately to all practising doctors, not just those who work in the NHS	DH and Dorothy Elsey with professional support from Dr Aileen Keel.
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.2 Appraisals - 360 degree feedback.	DH will consult with the GMC, the profession, the Medical Royal Colleges, patient groups and other UK Health Departments, and develop proposals to commission and pilot appropriate national tools for 360 degree feedback.	DH and Ricky Verral with professional support from Dr Aileen Keel

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Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.3 Formative and summative appraisals , leading to revalidation.	DH will discuss with the profession, their representatives, NHS Employers, the DAs, primary care organisations, NHS Trusts and other organisations that employ doctors proposals for the introduction of an appraisal process with summative components. The quality of the process will be regularly assured by the GMC. The appraisal arrangements will need to take account of the large numbers of doctors who work outside the NHS.	DH and Ricky Verral with professional support from Dr Aileen Keel
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.4 Specialist re-certification.	DH will ask the Academy of Medical Royal Colleges, working closely with the GMC, to establish a UK working group to support coordination and piloting of these processes, including ensuring equivalence of standards between medical Royal Colleges.	CMO / Dr Aileen Keel

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Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.5 Standards will be set for each area of specialist recertification by the appropriate medical Royal Colleges and specialist associations. These standards will be tested against the needs of patients and healthcare providers.	The standards will be agreed with the GMC to ensure that they are sufficient to meet the requirements for remaining on the appropriate part of the Medical Register. This work will be led by the Academy of Medical Royal Colleges.	CMO / Dr Aileen Keel
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.6 For some doctors working in other settings, the context for their work may require adaptation of specialist standards to the particular context in which they are currently working.	The Government will discuss with the DAs relevant stakeholders, the GMC and the Royal Colleges the best means of ensuring appropriate arrangements for doctors working in such contexts.	DH and Ricky Verral with professional support from Dr Aileen Keel
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.7 Both re-licensure and re-certification depend on objective assessment of doctors against clear standards. DH will discuss with the profession, NHS Employers and other stakeholders the best means through which these standards can be enshrined in the contracts of those doctors who are directly employed and in the commissioning arrangements for those doctors who work within the terms of contracts with	The DAs will consider appropriate arrangements for doctors working in Scotland, Wales and Northern Ireland.	WFD – Alex Killick / Head of NHSS Pay and Pensions for contractual issues – with professional input as required from Dr Aileen Keel.

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Subject Heading	White Paper proposal	Action	Lead official/s ²
	commissioners		
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.8 Local clinical audit , within the framework of clinical governance, needs to be revitalised.	A wide and inclusive clinical audit advisory group should be established in England to drive the further development of local and national clinical audit programmes and to establish how best <i>Connecting for Health</i> can support this work. DH will discuss with the DAs whether they would wish to participate in this work.	Colin Brown with professional support from Dr Sara Davies
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.9 As doctors approach retirement ; they should be invited to a review with their Medical Director or Responsible Officer to discuss whether continuation of their licence to practise beyond retirement would be desirable.	DH will discuss with the DAs, BMA, the GMC, patient groups and others the desirability of maintaining a register of retired doctors and the safety of allowing retired doctors to undertake occasional practice and to retain limited prescribing rights for a defined range of medicines.	DH and WFD - Alex Killick / Head of Staff Governance with professional support from Dr Aileen Keel

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Subject Heading	White Paper proposal	Action	Lead official/s ²
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.10 Where doctors who are working in clinical practice fail to satisfy the requirements of either element of revalidation , they should spend a period in supervised practice or out of practice, prior to assessment, in order that a tailored plan of remediation and rehabilitation may be put in place.	As part of the wider work set out in Chapter 4, DH will work with the DAs, GMC, the BMA, NCAS, the medical Royal Colleges, and others to agree appropriate arrangements and support mechanisms to enable this.	Alex Killick / Head of Staff Governance with professional support from Dr Aileen Keel
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.11 Revalidation of non-medical healthcare professions.	DH will ask the CHRE to work with regulators, the professions and those working on European and international standards to support this work. This will encompass the consideration of standards for higher levels of practice.	DH and CNO/Audrey Cowie with input from Chief Professional Officers
Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.12 There are some non-medical professional staff such as clinical scientists who undertake higher specialist training and practise for most of their careers at a specialist autonomous level.	DH will work with the DAs to establish a short-term working party to consider how regulation and revalidation should reflect this	DH and Audrey Cowie with input from Chief Professional Officers

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<p>Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise</p>	<p>2.13 Government agrees that the appraisal process within the NHS, which will be a central component of revalidation, should be both formative and summative, to ensure objectively that required standards are met. Information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis.</p>	<p>As these measures will require the introduction of summative elements to assessment, DH will discuss these proposals with the DAs, the relevant regulators, NHS employers, trades unions and others with an interest to ensure this is proportionate, fair and appropriate.</p>	<p>DH and CNO / Audrey Cowie with support of Workforce Modernisation Division – John Turner / Janis Millar.</p>
<p>Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise</p>	<p>2.14 In England, DH will include the capacity of organisations to carry out this role as a core component of the standards against which organisations are judged when they are granted their licence to operate by the new national system regulator.</p>	<p>DAs will consider how to address this within their particular contexts. [<i>Note: It is considered important by DH to ensure that the organizations, whether providers or commissioners, responsible for revalidation of healthcare professionals, are carrying out this duty in a sufficiently rigorous and fair manner to ensure patient safety and fair treatment of health professionals.</i>]</p>	<p>Patients & Quality Division with support from Workforce Employment & Retention; Workforce Planning & Development; Primary Care Division; the Regulatory Unit and Care Standards & Sponsorship Branch – Linda Gregson.</p>

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Chapter 2 Revalidation: Ensuring Continuous Fitness to Practise	2.15 The Government will discuss with the DAs, public, Independent and voluntary sector employers the development of an affordable and manageable timetable for the effective implementation of revalidation.	A UK Revalidation Steering Group will be established to develop and coordinate this work.	CNO / Audrey Cowie.
Chapter 3 Tackling Concerns – The Local Role	3.1 Concerns and behaviours are not exclusive to relationships with the medical profession but are significantly more pronounced within them. Other regulators, particularly for those professions in which there are strong and longstanding professional cultures, do encounter similar issues.	The Government will continue to consult on whether similar measures are required for other professions , but, for now, will focus these additional local regulatory measures on the medical profession.	DH and CNO / Audrey Cowie with input from Chief Professional Officers

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Chapter 3 Tackling Concerns – The Local Role	3.2 To ensure greater consistency of approach to the investigation of concerns about health professionals,	Government will ask the CHRE to work with stakeholders to develop common protocols for investigation across all the regulators, with guidance to employers on when cases should be referred to the national professional regulator.	DH and CNO / Audrey Cowie with input from Chief Professional Officers
Chapter 3 Tackling Concerns – The Local Role	3.3 The Government will be reviewing the current performer list arrangements in England to consider whether they are being used effectively. In particular, following the GMC's introduction of the GP Register in April 2006, the Government will consider the regulatory burden of separate lists being held by each PCT	Review performer list arrangements in Scotland, if necessary.	Jonathan Pryce / Martin Moffat / Dr Mini Mishra with input from Chief Professional Officers
Chapter 3 Tackling Concerns	3.4 For all doctors working in the UK, the Government will seek	The UK Government will discuss with the DAs how the GMC Affiliates in these	CMO / Dr Aileen Keel

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Subject Heading	White Paper proposal	Action	Lead official/s ²
– The Local Role	Parliamentary approval to establish a UK network of GMC Affiliates at regional level in England at a national level in Scotland, Wales and Northern Ireland	countries would operate.	
Chapter 3 Tackling Concerns – The Local Role	3.5 Establish more explicit competencies for the role of medical directors and measures to enhance their direct accountability to Boards for actions that relate to their new responsibilities and powers in relation to regulation and revalidation.	DH will lead a project to establish these competencies.	Dr Aileen Keel with input from Head of NHSS Pay and Pensions – Colin McGowan.

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Chapter 3 Tackling Concerns – The Local Role	3.6 A system of Recorded Concerns , for the local regulation of concerns about doctors' conduct or practice,	DH will discuss with key stakeholders from across the UK and with the DAs how to frame detailed proposals on the practical implementation of the new system of GMC Affiliates and Recorded Concerns through a piloted approach in England	Dr Aileen Keel and WFD - Ricky Verral
Chapter 3 Tackling Concerns – The Local Role	3.7 DH will consider, with stakeholders, the regulatory and other impacts of developing a more effective system of registration and inspection for agencies providing healthcare professionals.	The DAs will consider these issues in the context of their own regulatory frameworks	CNO / Audrey Cowie with input from Linda Gregson
Chapter 4 Tackling Concerns – The National Role	4.1 Standard of Proof	The Government agrees with Dame Janet Smith and the CMO that the civil standard of proof, with its sliding scale, should be the common standard of proof for all the regulatory bodies in fitness to practise proceedings.	DH and Catherine Clark

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Subject Heading	White Paper proposal	Action	Lead official/s ²
		Primary legislation	
Chapter 4 Tackling Concerns – The National Role	4.2 The Government will discuss with the Devolved Administrations, the Parliamentary and Health Service Ombudsman, the Healthcare Commission and CHRE what further arrangements would be appropriate to provide additional safeguards around initial investigation and screening of complaints about doctors.	Since 2005, a memorandum of understanding has been in place between the GMC and NHS Quality Improvement Scotland. Scotland will consider what further, if any, devolved arrangements would be appropriate to provide additional safeguards in Scotland and whether a common memorandum of understanding covering all healthcare professions, including those whose regulation is a devolved matter, would be desirable.	Hector Mackenzie / Health Planning & Quality
Chapter 4 Tackling Concerns – The National Role	4.3 For all the professional regulators, the Government will ask the CHRE to review a sample of cases that the regulators have not taken to full fitness to practise panels.	The Government will consider whether CHRE has the necessary powers to review the different fitness to practise cases, both their processes and application.	DH and CNO / Catherine Clark
Chapter 4 Tackling Concerns – The National Role	4.4 To ensure greater consistency of approach to the investigation of concerns about health professionals	The Government will ask the CHRE to work with stakeholders to develop common protocols for investigation across all the regulators and provide guidance to employers on when cases should be	DH and CNO / Audrey Cowie with input from Chief Professional Officers and other policy leads implicated.

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		referred to the national professional regulator.	
Chapter 4 Tackling Concerns – The National Role	4.5 DH will work with NCAS and with stakeholders in England to review the cost-effectiveness of extending its scope to other health professions, as suggested by the Public Accounts Committee.	Review whether there will be an equivalent ‘non-medical’ role for NCAS in Scotland.	CNO / Audrey Cowie with input from Chief Professional Officers
Chapter 4 Tackling Concerns – The National Role	4.6 Support and rehabilitation	Government will ensure that the GMC can support this new emphasis on support and rehabilitation for doctors by requiring NCAS and the GMC to work together with employers to agree specific packages of rehabilitation and conditions on practice, and will also examine whether professional indemnity insurance might be extended to address the costs of such packages.	DH and Aileen Keel, DCMO with input from Workforce Employment and Retention – Alex Killick

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Subject Heading	White Paper proposal	Action	Lead official/s ²
Chapter 4 Tackling Concerns – The National Role	4.7 Ill Health. To ensure an integrated, affordable and cost-effective approach to the health of health professionals, the Department will establish a wide-ranging and inclusive national advisory group to inform the development of a national strategy for health covering all health professionals	The DAs will consider whether they wish to participate in a UK wide strategy or whether to develop approaches tailored to the circumstances of Scotland, Wales and Northern Ireland.	DH and CNO/Audrey Cowie, Alex Killick, with input from Chief Professional Officers
Chapter 4 Tackling Concerns – The National Role	4.8 For doctors, the separation of investigation and prosecution from adjudication is essential to ensure complete public confidence in the independence of the decisions of the adjudicator.	Working closely with the GMC, the Government will seek legislative agreement to establish an independent body to adjudicate on fitness to practise cases involving the medical profession.	CMO / Dr Aileen Keel, Catherine Clark, with input from Workforce Employment and Retention
Chapter 4 Tackling Concerns – The National Role	4.9 Independent adjudication for all the other regulators.	The Government will charge the new independent body with establishing a central list of vetted and approved potential panellists for all adjudication panels, chosen by the Appointments Commission for their expertise and specifically trained to undertake these duties in a fair and impartial manner.	DH and CNO / Audrey Cowie / Catherine Clark

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Subject Heading	White Paper proposal	Action	Lead official/s ²
Chapter 4 Tackling Concerns – The National Role	4.10 Equality and diversity	Each regulator will be required, as part of their reports to Parliament, to provide information on equality issues relevant to regulation within their profession;	DH and CNO / Audrey Cowie / with input from Chief Professional Officers and other relevant policy leads
Chapter 5 Education – The Role of the Regulatory Bodies	5.1 Government agrees with the principle set out in the review of the regulation of the non-medical health professions that the professional regulatory bodies should continue to be responsible for the assurance of educational standards in those professions.	Government expects that the professional regulators will work collaboratively with the Sector Skills Council for Health.	DH and CNO / Audrey Cowie with input from Chief Professional Officers
Chapter 5 Education – The Role of the Regulatory Bodies	5.2 The Government agrees with the proposal, set out in the GMC's response to consultation, for a three board model covering undergraduate education, postgraduate education and continuing professional development.	The Government will work with the GMC to establish an undergraduate board and continuing professional development board. In establishing the new board on continuing professional development, the Government will ask the GMC to lead a consultation with key constituencies and stakeholders, including patients and the public, to consider what reforms are needed and to make recommendations accordingly.	DH and Ricky Verrall with professional input from Dr Aileen Keel

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		The Government will review the effectiveness of these new arrangements in 2011	
Chapter 5 Education – The Role of the Regulatory Bodies	5.3 Develop arrangements for selective language testing for applicants to posts, where appropriate	DH will ask UK regulatory bodies to work with NHS employers to develop arrangements for selective language testing for applicants to posts, where appropriate.	DH and WFD – Dorothy Elsey with input from Workforce Employment and Retention, Chief Professional Officers and other relevant policy leads.
Chapter 5 Education – The Role of the Regulatory Bodies	5.4 <i>Good Doctors, Safer Patients</i> raised the possibility of the introduction of a national examination prior to the initial registration of doctors with the GMC	European law would prevent this being introduced in the case of European applicants. The Government will discuss this further with the GMC, who are considering a range of options.	Professional input to DH -Dr Aileen Keel
Chapter 6 Information about Health Professionals	6.1 Agree a single standard of good character and promote information sharing on the good character of professionals who cross national borders.	Government will ask CHRE to agree this, working with the regulatory bodies and encompassing wider work within Europe.	DH and CNO / Audrey Cowie with input from Chief Professional Officers
Chapter 6 Information about Health Professionals	6.2 Ensure closer cooperation and coordination between regulators and employers when a health professional enters employment for the first time.	DH will ask the CHRE to lead a programme of work with regulators and employers to scope the feasibility and practicability of these proposals. As part of this work, the CHRE will need to explore with the NHS Connecting for Health Programme and equivalents in the DAs, the potential for such a system to be encompassed within the electronic staff record for the NHS in England	DH and WFD – Dorothy Elsey

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		and the equivalents in the DAs	
Chapter 6 Information about Health Professionals	6.3 Student registration.	DH will ask the regulators to report back with proposals by January 2008.	DH and CNO / Audrey Cowie/ Catherine Clark with input from Chief Professional Officers
Chapter 6 Information about Health Professionals	6.4 There should be changes to the Medical Register , ensuring it is the key national list of doctors entitled to practise in the UK.	DH will discuss with the GMC and stakeholders, including employers and the BMA , how the Register will be further developed to become the single authoritative source of information on doctors, including disciplinary action by employers and alert notices	DH and Alex Killick / Head of Staff Governance with professional input from Dr Aileen Keel
Chapter 6 Information about Health Professionals	6.5 The Government agrees with the recommendation in the review of non medical regulation that for the non-medical health professions post registration qualifications should be recorded in the register where these are relevant to patient care, risk management and are at a level substantially beyond the requirements for basic registration.	DH will ask the regulators what other changes should be made to provide better information for patients, the public and employers	DH and CNO / Audrey Cowie / Catherine Clark with input from Chief Professional Officers

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Chapter 6 Information about Health Professionals	6.6 Soft Intelligence. There is a dilemma about the extent to which information about health professionals held at local level should be shared at a national level.	DH will work with the other UK Health Departments, CHRE, the regulators, the professions, employers, NCAS, the public, and patients to draw up protocols and systems for managing this information effectively, taking into account recommendation 35 of the Shipman Inquiry on the handling of such information	DH and WFD – Ricky Verrall with input from Chief Professional Officers
Chapter 7 New Roles and Emerging Professions	7.1 The Government has made clear commitments to introduce statutory regulation for applied psychologists, several groups of healthcare scientists, psychotherapists and counsellors and other psychological therapists, and herbalists and acupuncturists	In Scotland, regulation for professions being regulated for the first time is a matter devolved to the Scottish Parliament	DH and CNO / Catherine Clark / Audrey Cowie with input from Chief Professional Officers
Chapter 7 New Roles and Emerging Professions	7.2 The regulation of emerging and existing unregulated professions across the UK will be managed by the existing statutory regulatory bodies, subject to the agreement of the DAs.	DH in consultation with the DAs, will establish a UK working party to develop criteria to determine which roles should eventually be statutorily regulated across the UK.	CNO / Audrey Cowie / Catherine Clark with input from Chief Professional Officers
Chapter 7 New Roles and Emerging Professions	7.3 Harmonisation of regulatory practice and legislative provisions across the regulators so that all have the most	The Government will consider, together with DH, areas which could be harmonised.	CNO / Audrey Cowie and Catherine Clark with input from Chief Professional Officers as required

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	up to date and comprehensive duties and powers.		
<p>Chapter 7 New Roles and Emerging Professions</p>	<p>7.4 Where a health professional joins a new regulated profession group from within an existing regulated profession, it might be possible for them to remain registered with their existing regulator, in a system of distributed regulation, to avoid costly dual regulation</p>	<p>The Government will explore the practicality of a system of distributed regulation, including its relationship to revalidation, in which a lead regulator will regulate a new profession and register most of its practitioners, including direct entrants. The Government will consider further the legal and operational practicalities of ensuring that these practitioners meet the same standards as everyone else in the new profession while continuing to meet the requirements of their original regulator</p>	<p>CNO / Audrey Cowie with input from Chief Professional Officers</p>

(updated following meeting of 22nd October 2007)

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Chapter 7 New Roles and Emerging Professions	7.5 Healthcare Support Workers. The Government in England will evaluate the results of the Scottish pilot study and consider the way forward with stakeholders.	The Government will consider whether there is sufficient demand for the introduction of statutory regulation for any assistant practitioner roles at levels 3-4 on the Skills for Health Career Framework	CNO / Audrey Cowie / Catherine Clark with input from Chief Professional Officers as required
Chapter 8 Implementation	8.1 Publication of a detailed implementation programme prior to introduction of primary legislation to enable the implementation of the reform programme set out in this White Paper.	The Government will consult with the DAs, the regulators, the professions, employers and other key stakeholders on the development of this programme.	DH and CNO / Audrey Cowie / Catherine Clark
Chapter 8 Implementation	8.2 Primary legislation is likely to be required for: enabling regulators to adopt lay majorities for their Councils; changes to the Council for Healthcare Regulatory Excellence; changes to the Royal Pharmaceutical Society of Great Britain; changes to enhance the independence of adjudication; the	These legislative proposals will be developed in close consultation with the DAs to ensure that UK proposals are appropriate.	CNO / Catherine Clark

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	delivery of revalidation; the establishment of GMC Affiliates; and changes to the powers and responsibilities of Medical Directors and their equivalents.		
Chapter 8 Implementation	8.3 Other measures need to be enabled by seeking Parliamentary approval for secondary legislation . On specific matters where there are clear public, professional and parliamentary agreement on the need for change, DH will consider with stakeholders whether it would be appropriate to seek Parliament's agreement in primary legislation to enable these issues to be addressed through secondary legislation	These legislative proposals will be developed in close consultation with the DAs to ensure that UK proposals take full account of the constitutional arrangements for matters that are devolved to the DAs.	CNO / Catherine Clark
Chapter 8 Implementation	8.4 The White Paper sets out the key principles for a lasting settlement for professional regulation , but putting those principles into practice effectively will require the advice and participation of a wide range of stakeholders to ensure effective delivery.	The Government, together with the DAs, will establish an inclusive national advisory group on professional regulation to advise them on the detailed implementation of the White Paper.	DH and CNO / Audrey Cowie

SGHD Programme Management Structure for implementation in Scotland**Sponsoring Director: Paul Martin, CNO****Implementation Lead: Audrey Cowie**

Name of Group	Remit of Group	Timescale and regularity of meetings	Chair and lead official
SGHD Regulators' Liaison Group	To advise SGHD and provide reference for the implementation of regulatory White Paper in Scotland	Set up January 2007 - meet every three months (currently being reviewed).	Paul Martin with Audrey Cowie
<i>The Regulation of Health Professionals in the 21st Century</i> – Overarching Implementation Steering Group	To steer the implementation of the White Paper in Scotland in line with the Programme Initiation Document	1 st meeting 9 July 2007 – meet every three months (cross-membership with the Regulators' Liaison Group)	Joint Chairs: Paul Martin, CNO and CMO. Professional support from Audrey Cowie.

(updated following meeting of 22nd October 2007)

Name of Group	Remit of Group	Timescale and regularity of meetings	Chair and lead official
<p><i>The Regulation of Health Professionals in the 21st Century</i> –</p> <p>Short-life implementation groups</p>	<p>To advise on the practical implications of implementing the White Paper in Scotland</p>	<p>Set up by October 2007 – meet two-three monthly as short-life groups.</p>	<p>Policy leadership as indicated in Annex A.</p> <p><i>[It is anticipated that each of the two Implementation Groups (“Cross-professional fitness to practice” and “Extending Professional Regulation”) will require a number of associated workstreams. Stakeholder mapping will ensure that all interests are served as far as is practical.]</i></p>
<p><i>The Regulation of Health Professionals in the 21st Century</i> –</p> <p>SGHD Programme Management Team</p>	<p>To be responsible for the ongoing programme management to deliver implementation of the White Paper in Scotland</p>	<p>Set up February 2007 – ongoing day to day management</p>	<p>Audrey Cowie with Catherine Clark and Susan Campbell <i>[additional support to be secured for secretariat, legislative work, etc].</i></p>