

**Scottish Government Health Directorates**

**UK GOVERNMENT WHITE PAPER – TRUST, ASSURANCE AND SAFETY – THE REGULATION OF HEALTH PROFESSIONALS IN THE 21<sup>ST</sup> CENTURY**

**IMPLEMENTATION IN SCOTLAND - UPDATE**

<b>PROGRAMME OF WORK</b>	<b>OVERALL OBJECTIVE / S</b>	<b>SUMMARY OF UK PROGRESS AND INTERVENTIONS REQUIRED ON BEHALF OF SGHD</b>	<b>RAG STATUS [with explanatory comment as necessary]</b>
<p><b>1. Assuring independence: the governance and accountability of the professional regulators</b></p>	<p>To establish and sustain confidence in the independence of the Professional Regulatory Bodies.</p>	<ul style="list-style-type: none"> <li>• Scotland was represented on the DH Enhancing Confidence Working Group, whose final report in November 2007 made 32 recommendations, most of them accepted by Ministers across the UK.</li> <li>• Three “Section 60” Orders have since been made to put elements in place which are aimed at increased harmonisation and accountability. Together they provide for smaller, more Board-like Councils for all the regulators, appointed rather than elected; and for their increased accountability to Parliament, including the Scottish Parliament where the regulator</li> </ul>	<p>GREEN</p>

		<p>operates in devolved areas.</p> <ul style="list-style-type: none"> <li>• The last of the three Orders also extended regulation to pharmacy technicians in Scotland and introduced regulation for practitioner psychologists across the UK.</li> <li>• Constitution Orders are now in place for all the regulators. Council members are selected by the Appointments Commission for a maximum of two 4-year terms.</li> <li>• The Health and Social Care Act 2008 ensured that the CHRE still has one member appointed by the Scottish Ministers. All the other regulators are required to have at least one Council member who lives or works wholly or mainly in Scotland. Scotland has been represented on all interviewing panels for Scottish members, and all the new Councils are in place for existing regulators, except for the Royal Pharmaceutical Society of Great Britain, whose regulatory functions are to transfer to the new General Pharmaceutical Council (GPhC) in 2010.</li> <li>• Each Council will be required to produce a set of key performance indicators.</li> <li>• The CHRE's annual assessment of each regulator's performance will be provided by the CHRE to the relevant Parliament. In the case of Regulatory Bodies operating in devolved areas this will include the Scottish Parliament.</li> <li>• Regulators have a responsibility to ensure that</li> </ul>	
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		<p>all employers understand when it is appropriate for complaints to be referred to the Professional Regulator. CHRE was charged with coordinating this work and has now published its report. Scotland may consider that further work is required.</p> <ul style="list-style-type: none"> <li>• The General Pharmacy Order - which will set up the new GPhC to take on the regulatory role of the Royal Pharmaceutical Society of Great Britain will shortly be laid for approval by resolution of both Westminster and the Scottish Parliament. The RPSGB will continue in a professional role analogous to a Royal College. SGHD provided input to the drafting of the Order. Once the General Pharmacy Order is made, a series of statutory instruments will follow to put in place associated rules and regulations. A draft Constitution Order was issued for joint consultation with the Scottish Ministers on 27 October. It will close on 25 November 2009 and can be viewed here: <a href="http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_107537">http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_107537</a></li> <li>• Meantime, the shadow Council, and Chair Designate have been announced and their appointments will be formally confirmed once all relevant legislation is in place. The new Chief Executive has also been announced.</li> <li>• The latest edition of the DH Professional</li> </ul>	
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		Standards Programme newsletter can be found at the following link: <a href="http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/index.htm">http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/index.htm</a>	
<b>2. Medical Education and Revalidation</b>	<p>To implement objective and periodic reaffirmation of continuing fitness to practise – for doctors in first instance.</p> <p>Professional Regulatory Bodies to continue to be responsible for the assurance of standards (including educational) for the professions.</p>	<ul style="list-style-type: none"> <li>• The DH working group, on which SGHD was represented, published its final report on revalidation and has since been disbanded.</li> <li>• Revalidation for doctors will be a five year continuous process rather than an event.</li> <li>• It is likely to be informed by locally-based annual appraisal, periodic multisource feedback (MSF) and documentation of outcomes of any complaints. Information from clinical audit data could also be included but this is not yet certain and the issues continue to be discussed.</li> <li>• Implementation will be carefully piloted. Licensing will be commenced in Scotland as well as the rest of the UK on 16 November 2009. Licensing will be the first step towards implementation of revalidation, which will not commence before 2011 [NB CMO England's report states that the GMC will discuss with the Devolved Administrations how the timetable may need to differ for each country.].</li> <li>• MSF tools will need to meet the principles set by the GMC; the actual process is yet to be confirmed. The GMC will develop and consult on principles for MSF in early 2010 and is</li> </ul>	<p>AMBER -&gt; GREEN [Revalidation not yet implemented but excellent progress being made by GMC and within Scotland]</p>

		<p>continuing to commission research into its own MSF tool.</p> <ul style="list-style-type: none"><li>• Annual appraisal for doctors will be standardised and reviewed to ensure that it is fit for the purpose of revalidation. “Good Medical Practice” has been categorised into 4 domains and 12 attributes. The GMC has produced a Framework for Appraisal and Assessment which maps types of evidence to each attribute for the purposes of re-licensing. The Academy of Medical Royal Colleges has issued a closely linked Framework for Specialty Standards to support recertification. The GMC will consult on the Good Medical Practice Framework and Specialty Standards in early 2010.</li><li>• In Scotland, we hope to investigate the type of information to be gathered (for secondary care) in NHS Highland, in close collaboration with the GMC, as part of a pilot scheme. SGHD is leading on the pilot and the UK Academy of Medical Royal Colleges will also be involved.</li><li>• A further pilot is being carried out within NHS Lothian on managing poorly performing doctors. The pilot is being carried out in collaboration with the GMC as well as the National Clinical Assessment Service (NCAS) and aims to develop general guidance for local systems about the processes that should be in place to deal with poor performance. Further work is</li></ul>	
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		<p>taking place within SG Health Workforce Directorate on related policy.</p> <ul style="list-style-type: none"> <li>• The CMO in Scotland requested that all NHS Boards produce an annual report on the performance of appraisal of doctors in Spring 2008. The draft reports highlight a considerable variation in the quality of appraisal across the boards in secondary care. The summary report has been circulated and provides NHS Boards with a clear view of their relative performance, highlighting action for each to take in specific areas. A reminder to return the reports for 2008-09 has been sent.</li> <li>• NES has produced a costed scoping report in relation to the training of appraisers in secondary care. A pilot scheme is in preparation. NES already provides a national appraiser training scheme for primary care.</li> <li>• NHS QIS has agreed in principle to provide the External Quality Assurance of appraisal in both primary and secondary care. Initial scoping work is currently being carried out by QIS.</li> <li>• A Scottish Appraisal Leads Group has been established under the joint chairmanship of Professor Paul Padfield of NHS Lothian and Dr Mark MacGregor, NHS Ayrshire and Arran. It has representatives from primary and secondary care from each NHS Board and is tasked with continuous improvement and harmonisation of</li> </ul>	
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		<p>appraisal across Scotland.</p> <ul style="list-style-type: none"><li>• The Appraisal Leads Group aims to agree on the information required for appraisal. Standard paper documentation is being developed initially for NHS Scotland, but this may be overtaken by a web-based solution over time. Development of the standardised documentation is well advanced and close to completion.</li><li>• The group is also assessing the various potential website tools for managing appraisal information (including the NES ePortfolio, the Scottish Online Appraisal Resource (SOAR), the NES primary care resource and that being developed by the Revalidation Support Team in / for England).</li><li>• Revalidation (both re-licensure and recertification) will consist of a <u>single</u> process with dual outcomes. Progress with recertification is, however, at different stages across the different Royal Colleges. The Academy of Medical Royal Colleges (AoMRC) has asked each College and Faculty to map the GMC framework to the required evidence for each specialty and for each grade of doctor. AoMRC also has workstreams addressing CPD, specialty-specific MSF, ePortfolios for revalidation, evidence required for non-clinical work and remediation. There is also a Scottish</li></ul>	
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		<p>Academy Revalidation Group which is feeding in.</p> <ul style="list-style-type: none"> <li>• In Scotland, a Responsible Officer's (RO) Network has been set up with Dr Frances Elliot chairing and membership including all Executive Medical Directors in Scotland, who we expect will be the Responsible Officers of the future. The terms of reference of this group focus on the practical implications, at Board level, of implementing the Responsible Officer role across Scotland. It aims to function as a shadow RO network pending (reserved) legislation to put ROs in place. A Department of Health consultation on the draft RO regulations and guidance closed on 25 October. Responses are being considered along with the Devolved Administrations for the final version to be laid at Westminster.</li> <li>• A UK Revalidation Programme Board has been set up by the GMC. It is chaired by Keith Pearson, CBE, and Dr Frances Elliot represents Scotland's CMO on the Board. The Board is supported by the GMC's Revalidation Project Executive Group and the GMC's Revalidation Communications Forum, both of which have representation from SGHD. This Programme Board will oversee the delivery of revalidation by all four UK countries. Feeding in to this is the Scottish Revalidation Delivery Board, chaired by</li> </ul>	
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		<p>Frances Elliot, a workstream emanating from our Cross-Professional Fitness to Practise Group, which will focus on the practical implications of delivering medical revalidation in Scotland. This Board has met three times to date, a further meeting will take place on 24 November..</p> <ul style="list-style-type: none"> <li>• It is clear that successful revalidation needs to be underpinned by high quality systems of clinical governance. This will be key to success.</li> <li>• NHS Quality Improvement Scotland will be assisting NHS Boards with assessments of clinical governance and appraisal, and NHS Education for Scotland in the training of appraisers and facilitating appraisal.</li> <li>• An Order (reserved) has been made at Westminster which will pave the way for relicensing and revalidation. Following a GMC consultation, rules are being progressed relating to the introduction of licences.</li> <li>• In order to rationalise the regulation of medical education, PMETB will be merged with the GMC in April 2010. The GMC has established a three board model dealing with undergraduate education, postgraduate education and continued practice. SGHD provided input to the consultation on the draft legislation, which closed on 28 August. It has been established that the draft section 60 Order to be laid shortly for approval by both Houses at Westminster</li> </ul>	
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		<p>does not contain any devolved element, therefore it will not have to be laid in the Scottish Parliament too. The associated subsequent Order of Council will be made then laid at Westminster..</p> <ul style="list-style-type: none"> <li>• <i>Good Doctors, Safer Patients</i> suggested the introduction of a national qualifying examination for undergraduates. This is one of a range of issues to be considered in a review commissioned by the GMC, with support from PMETB, led by Lord Naren Patel. The review will consider the policy implications of the establishment of a single continuum for regulating medical education and training. It is expected to report early in 2010. There will be maximum stakeholder input to the work of the review.</li> </ul>	
<p><b>3. Non-Medical Revalidation</b></p>	<p>To implement objective and periodic reaffirmation of continuing fitness to practise – for all non-medical healthcare professional in due course [starting with nurses in 2010 – 11].</p>	<ul style="list-style-type: none"> <li>• The DH working group met for the fifth and final time on Thursday 10 July 2008.</li> <li>• The 5<sup>th</sup> meeting focused on agreeing the <i>high level principles</i> for revalidation, which had been the subject of two previous rounds of comments from members. The final document is now available on the DH website - <a href="http://www.dh.gov.uk">www.dh.gov.uk</a>. The Regulatory Bodies are now progressing work on models of revalidation that are fit for purpose for their respective registrants. It is unlikely that approaches will be harmonised.</li> <li>• At an extraordinary meeting held in London on</li> </ul>	<p>AMBER -&gt; GREEN</p> <p>Work has progressed with each RB having commenced initial work on a profession-specific plan</p>

		<p>24 March 2009, the group received a report on commissioned work that was looking at the feasibility of using the principles of a framework, such as the KSF, to provide evidence that would be needed for revalidation in both NHS and non-NHS settings.</p> <ul style="list-style-type: none"> <li>• Sue Hill, the Chief Scientific Officer at DH, previously gave a presentation on the career framework for healthcare scientists and what she perceived as the regulatory implications. This covered the different levels of practice from entry level to advanced practice. It is unclear at this stage whether the HPC will be implicated in all levels or whether there will be a Professional Body that takes responsibility for, for example, “advanced” [yet to be clearly defined] levels of practice. The new model is causing some anxieties in terms of its implications for existing groups and those already regulated. The report from CHRE on how regulatory bodies handle practice that goes beyond the normal scope of practice is relevant here (see web-link below).</li> <li>• The need for recognition by regulatory bodies of a level of “Advanced Practice” is currently being debated following the CHRE’s recent completion of its final report on its commission to develop a shared understanding of advanced practice across the regulators, with clear differentiation between what is required for public protection</li> </ul>	<p>for revalidation. Not all plans have yet been shared publicly.</p>
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		<p>and what complements professional standing. The Report was published in July and is available from the CHRE website <a href="http://www.chre.org.uk/img/pics/library/090709_Advanced Practice report FINAL.pdf">http://www.chre.org.uk/img/pics/library/090709_Advanced Practice report FINAL.pdf</a></p>	
<p><b>4. Tackling concerns: the local role</b></p>	<p>The overarching Tackling Concerns Locally working group is coordinating a series of reforms which will strengthen local arrangements for identifying poor practice among healthcare workers and taking effective action where poor practice is suspected. The main working group coordinated the work of six sub-groups. The Scottish Government had membership on all six – as an observer on those where policy was being made for England only. The report of the main Group was published on 20 March 2009 and was accompanied by reports from three of its six sub-groups. A brief overview of the remits of the</p>	<ul style="list-style-type: none"> <li>• The DH overarching group published its final report on 20 March 2009.</li> <li>• <u>GMC affiliates in England</u>: GMC affiliate pilots, at a regional level, were commenced in Yorkshire and London in September and October 2008 respectively. The Yorkshire pilot on 30 August 2009, and London pilot concluded on 30 September 2009. The final report was due to be signed off by the Affiliates Sub Group on 3<sup>rd</sup> Nov. It is the intention that the GMC affiliate will be paired with a lay affiliate. The lay affiliate will be a senior GMC employee. The affiliates' key roles will include supporting Responsible Officers in England, ensuring consistency of approach and providing advice on individual cases. <i>Scotland will await the result of the pilot/s before considering whether there is a need for GMC affiliates / similar in Scotland. A mapping exercise, of structures and processes in place in Scotland, has been completed against White Paper requirements and few gaps were identified.</i></li> <li>• <u>Responsible officers (ROs)</u>: The Health and</li> </ul>	<p>AMBER [work relating to sub-groups not all completed]</p> <p>Scotland not implicated in all aspects of the RO role and will continue to observe the outcomes of GMC Affiliate pilots in England.</p>

	<p>six sub groups follows.</p> <p><u>GMC Affiliates Subgroup</u> Develop and pilot a new system of GMC affiliates at local level. These bodies will provide the General Medical Council with a regional presence in order to support arrangements for joint working between local employers and the GMC.</p> <p><u>Responsible Officer Subgroup</u> Develop a new role of Responsible Officer so that in future all practising doctors in England will relate to a Responsible Officer who will be a senior doctor with local responsibility for overseeing the revalidation process and handling complaints against doctors.</p> <p><u>Information Management Subgroup</u> Design and implement</p>	<p>Social Care Act 2008 provided for regulations designating the bodies to be required to be ROs, and the duties and functions of ROs. SGHD provided input to the DH 3 month consultation undertaken in 2008 on the proposed policies in this area. This is a reserved area, but the UK Secretary of State is required to consult the Scottish Ministers on any such regulations to apply in Scotland. SGHD has provided input to the drafting of the Order, associated impact assessment and guidance issued by DH. These were consulted on for a 2-month period from 25 August to 25 October 2009. Consultation responses are currently being considered and work on the Regulations and Guidance document is continuing. It is anticipated that in NHS Scotland ROs will be the Board Executive Medical Directors. All doctors will have to relate to a Responsible Officer, and independent healthcare services will also be required to nominate or appoint a RO. In Scotland, Medical Directors may also take on that role for a small number of doctors not employed or contracted with their Boards. The key roles of the RO will be oversight of the revalidation process, and proactive liaison with the GMC. The draft Regulations being consulted on include additional clinical governance functions for ROs in England only.</p>	
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	<p>systems for sharing information that could lead to early identification of poor practice in order to better protect the public. This sub-group's report was published at the same time as the main Group's report on 20 March 2009.</p> <p><u>Clinical Governance Subgroup</u>          Improve systems for local investigation and local decision making to ensure patient safety and quality assurance through revitalisation of clinical governance processes. This sub-group's report was published at the same time as the main Group's report on 20 March 2009.</p> <p><u>Death Certification Subgroup</u>          Develop an improved system for death certification to ensure greater scrutiny of the</p>	<ul style="list-style-type: none"> <li>• <u>Regional Medical Regulation Support Team in England:</u> These regional groups (at SHA level in England), will include all the relevant stakeholders such as Responsible Officers, GMC affiliate, Postgraduate Deans and an NCAS representative. They will meet regularly to gain an oversight of regulatory activity in that region, to maintain consistency and to learn from each other. There is no perceived need for these teams in Scotland. The GMC ran a stand at the SGHD Stakeholder event on 27 and 28 October 2009, which would fulfil the networking, educational and information sharing aspects of these teams and give an update on the progress of responsible officers. A Responsible Officer Network has been established in Scotland and the GMC is working with Scottish Medical Directors on a proposed model for closer working.</li> <li>• <u>Recorded concerns:</u> This concept remains troublesome and has little support from stakeholders. It remains unclear who would store such "recorded concerns" given that if the concern is serious enough to warrant recording then it should be officially and robustly investigated. Current thinking seems to limit recorded concerns therefore to matters which have been formally investigated thereby negating the need for a separate process. Some</li> </ul>	
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	<p>medical certification of cause of death process.</p> <p><u>Performers List Subgroup Review</u> the current Performers List arrangements (under which GPs and other primary care contractors must be registered with a Primary Care Trust in order to practice locally), with a view to ensuring that they continue to provide necessary and appropriate safeguards. This sub-group's report was published at the same time as the main Group's report on 20 March 2009.</p>	<p>of these issues will, hopefully, be explored through the piloting of GMC Affiliates. The related provisions in the Health and Social Care Act 2008 do not extend to Scotland and this was carefully negotiated.</p> <ul style="list-style-type: none"> <li>• <u>Information Handling</u>: This group worked on the English agenda with observers from Scotland. It is anticipated that the outputs will be useful to England, and Scotland will observe with interest. There has been a call for a single point of entry for patient complaints and support.</li> <li>• The discussions and outputs from groups relating to devolved areas, such as <u>Clinical Governance</u> and <u>Performers' lists</u>, are being observed with advice and information shared on Scottish systems as required.</li> <li>• Three sub-groups from the Tackling Concerns Locally Group have submitted their reports (Clinical Governance, Information Management and Performers List) and the final publications can be found under "Tackling Concerns Locally" at: <a href="http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/ProfessionalRegulationandPatientSafetyProgramme/index.htm">http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/ProfessionalRegulationandPatientSafetyProgramme/index.htm</a></li> </ul>	
<p><b>5. Tackling concerns: the national role</b></p>	<p>To improve the investigation of concerns about health</p>	<ul style="list-style-type: none"> <li>• The Health and Social Care Act 2008 provided for the civil standard of proof to be used by all</li> </ul>	

	<p>professionals at a local level, and to assure confidence in medical practice in particular, including improving the way concerns about health professionals are managed nationally.</p>	<p>the healthcare regulators. Some of them – the GMC, NMC and GOC have historically used the criminal standard, although the GMC adopted the civil standard for new hearings on 31 May 2008. The requirement to use the civil standard was commenced on 3 November 2008 following the required consultation with the Scottish Ministers.</p> <ul style="list-style-type: none"> <li>• The CHRE has produced reports on both the threshold for investigation, and on the establishment of common protocols for investigation. SGHD had input into both of these reports.</li> <li>• NCAS began to formally operate in Scotland on 1 April 2008 after opening an office in Edinburgh. A Service Level Agreement between the Scottish Ministers and NCAS is in place. The activities of NCAS in Scotland are currently limited to doctors and dentists, but in England have been expanded to include pharmacists.</li> <li>• The Health and Social Care Act 2008 provided for the Office of the Health Professions Regulators Adjudicator (OHPA) to be set up, but to adjudicate only in the GMC's and General Optical Council's fitness to practise cases in the first instance. This is a reserved area. The DH Tackling Concerns Locally Working Group's Report on the establishment of the OHPA was published on 19 March 2009. Following the</li> </ul>	
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		<p>conclusion of a 3-month DH consultation on draft regulations for the proposed composition of the OHPA, responses are being considered by DH for the final version. Meantime, the Chair and non-executive Council members have been appointed pending the required legislation being in place. In the meantime, regulatory bodies other than the GMC and GOC will continue to perform both the adjudication and investigation roles.</p>	
<p><b>6. Information about health professionals</b></p>	<p>To ensure that information on the professional credentials of health professionals are more easily accessible to patients, the public, professionals and employers.</p> <p>To ensure that entry to the register is managed appropriately for patient safety and that the registers themselves provide information, with appropriate safeguards, to enhance patient safety.</p>	<ul style="list-style-type: none"> <li>• There is ongoing discussion about what information should be held by regulators and others about individual registrants.</li> </ul>	<p>AMBER [satisfactory progress being made but much work still to be done].</p>
<p><b>7. Council for Healthcare</b></p>	<p>CHRE is charged with</p>	<ul style="list-style-type: none"> <li>• The civil standard of proof is now applicable to</li> </ul>	<p>AMBER –</p>

<p><b>Regulatory Excellence – White Paper commissions</b></p>	<p>taking forward a number of commissions as a result of White Paper policy intentions.</p> <ul style="list-style-type: none"> <li>• CHRE is to advise on development of common standards and systems across professional groups where this would benefit patient safety.</li> <li>• CHRE is to advise on how Advanced Practice should be addressed, if at all, from a regulatory perspective.</li> <li>• CHRE is to work with stakeholders to develop common protocols for investigation and referral to Regulatory Bodies.</li> <li>• CHRE to investigate the feasibility of closer cooperation between regulators and employers when a health professional enters employment for the first time.</li> <li>• CHRE to provide advice</li> </ul>	<p>regulation across all healthcare professional groups. CHRE is discussing with key players the potential for a shared Code of Conduct across the professions and also the potential for sharing certain functions. The Regulatory Bodies have already agreed on a set of shared values. The Office of the Health Professions Adjudicator will also be implicated in this policy intention in the future.</p> <ul style="list-style-type: none"> <li>• CHRE has produced its final report in relation to its commission on Advanced Practice. SGHD provided significant input.</li> <li>• CHRE has drafted a report on common protocols for investigation which was put to the Tackling Concerns Locally Clinical Governance sub-group. In summary, CHRE has concluded that improving communications and improving access to existing advice from Regulatory Bodies is more proportionate and practical than producing common protocols.</li> <li>• CHRE has consulted on the need for adequate information and close co-operation between regulators and employers when a health professional enters employment for the first time. CHRE has concluded that there is no need for extra regulatory burden.</li> <li>• CHRE has consulted on how to ensure students are made aware of their responsibilities as health professionals at an early stage. CHRE</li> </ul>	<p>GREEN [satisfactory progress being made but some work still to be done].</p>
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	<p>on systems and processes for ensuring that students are fit to undertake education and training as health professionals; and whether students and trainees should have closer relationships with their future regulators prior to qualification and how this might be achieved.</p> <ul style="list-style-type: none"> <li>• CHRE to recommend a single standard definition of good character.</li> </ul>	<p>has concluded that a stronger relationship is needed between the education provider, Regulatory Body and student through Codes of Conduct and guidelines for fitness to practise.</p> <ul style="list-style-type: none"> <li>• CHRE has consulted in relation to its work on a definition of good character. It is clear that this is an area hampered by complexity – both in definitional and practical terms.</li> </ul>	
<p><b>8. New roles and emerging professions</b></p>	<p>To consider the scope of statutory regulation and other models.</p> <p>To ensure that any future system of regulation is proportionate to the risks and benefits entailed.</p>	<ul style="list-style-type: none"> <li>• This whole area is one that is devolved to the Scottish Parliament.</li> <li>• The final report by the Chair of the DH Extending Professional Regulation (EPR) group was published on 16 July 2009 and is available from the DH website (<a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102824">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102824</a>).</li> <li>• Its recommendations were largely endorsed by Ministers in all 4 UK countries. SGHD fed in to all drafts via direct membership and through comments from its own EPR group. The report</li> </ul>	<p>AMBER – GREEN</p>

		<p>will be the subject of day 2 of the annual regulation event to be held on 28 October 2009.</p> <ul style="list-style-type: none"> <li>• Criteria for statutory regulation have been considered and further work will assist decisions on whether new groups of healthcare workers require statutory professional self-regulation, or another proportionate form, in order to protect the public. SGHD is working to influence decisions regarding both regulation of new groups and choice of Regulatory Body with a view to continued UK wide regulation.</li> <li>• The DH group commissioned work on exploring different models of regulation and on the levels of risk associated with different types and levels of practice. Work on the development of a risk assessment tool will progress. This work will provide a much needed evidence base for future regulatory decisions.</li> <li>• A model of employer-led regulation has been piloted in Scotland as one of the alternative models to statutory regulation. The pilot, which was independently evaluated by the Scottish Centre for Social Research, and managed by NHS Quality Improvement Scotland on behalf of SGHD, took place in three NHSS Boards and one independent hospital, on behalf of the 4 UK countries, between January 2007 and December 2008.</li> <li>• The report from the independent evaluation was</li> </ul>	
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		<p>published on 5 June 2009 and is available from the Scottish Government website (<a href="http://www.scotland.gov.uk/Publications/2009/06/01144730/0">http://www.scotland.gov.uk/Publications/2009/06/01144730/0</a>).</p> <ul style="list-style-type: none"> <li>• The Cabinet Secretary largely endorsed its recommendations. Ministers in the three other UK Health Departments have indicated they will draw on the evidence from the report to inform future decision making. Implementation of recommendations in Scotland is being pursued through a partnership approach. A Scottish Government Strategic Implementation Group was set up to take forward implementation of Mandatory Standards and Codes for Healthcare Support Workers across NHSS Boards by late 2010. Its final meeting was on 12 November 2009.</li> <li>• The HCSW project has been a high profile piece of work which has broken new ground in the regulatory field. It illustrates well the move from Government to governance in pursuit of proportionate reactions to calls for regulation. It is as yet unclear, however, whether the model is workable across the rest of the UK, governance arrangements and accountability relationships between Ministers and the NHS being different in each of the four countries.</li> <li>• The Cabinet Secretary launched the Codes and Standards at the 2<sup>nd</sup> annual regulation event on</li> </ul>	
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		<p>28 October 2009.</p> <ul style="list-style-type: none"> <li>• Regulation of Healthcare Scientists and of Psychotherapists and Counsellors is being considered.</li> <li>• A 3-month DH joint consultation with the Scottish Ministers and the other Devolved Administrations on the regulation of herbalists, acupuncturists and practitioners of Chinese herbal medicine closed on 16 November 2009. Responses will inform future decisions in this area, as will the report of the DH Extending Professional Regulation Working Group.</li> <li>• The HPC is currently considering responses to its consultation on the recommendations from its Professional Liaison Group on the regulation of psychotherapists and counsellors: (<a href="http://www.hpc-uk.org/aboutus/consultations/index.asp?id=93">http://www.hpc-uk.org/aboutus/consultations/index.asp?id=93</a>)</li> <li>• Regulation has now commenced for practitioner psychologists (HPC) and pharmacy technicians (RPSGB).</li> <li>• The Health and Social Care Act 2008 made provision for the Hearing Aid Council to be dissolved. The required section 60 Order has now been laid at Westminster. This transfers the regulation of hearing aid dispensers in the private sector to the HPC from 1 April 2010, thus ensuring that the registration of this group continues. The regulation of hearing aid</li> </ul>	
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		dispensers in the public sector will follow later.	
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November 2009