Department of Health: Promoting professionalism, reforming regulation

Response of the Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh ("the College") was founded in 1681. We support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties. Our UK Fellows and Members work in the NHS across the four nations of the UK, including 50% in the NHS in England, and we welcome the opportunity to submit views to this consultation.

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

Yes. The College agrees that the PSA is well placed to take on the role of advising the UK governments on which groups of healthcare professionals should be regulated on a statutory and voluntary basis, both now and in the future.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

The College has a number of queries regarding the proposed criteria, particularly around the perception of risk. It is important to note that it is professions which are regulated, rather than particular activities or locations. The criteria should be balanced with the need for equity across professional groups.

Assessing risk of harm may be difficult to apply practically depending on the criteria used: for example, should a physical therapist working in a care home be regulated in a different manner to a physical therapist who works in a patient's private home? It is important for the criteria to not be overly restrictive in this regard and to take full account of patients' needs.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

Yes: it is entirely right that doctors are already subjected to the highest level of regulatory oversight and the College supports the appropriate level of application of the principles of regulation across the professions. This should always be proportionate to risk and avoid excessive bureaucracy.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

The College does not support the use of prohibition orders in this regard and they should not be viewed as an alternative to statutory regulation. The use of prohibition orders is essentially negative and their use would not give confidence to patients or the public about the standard of a health professional.

Q5: Do you agree that there should be fewer regulatory bodies?

In principle yes, the College agrees as there are persuasive arguments for this, largely linked to economies of scale. To be effective, a regulator must be efficient and consideration must be given to the most efficient use of support services and how smaller professions are regulated.

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

Advantages are likely to be largely linked to economies of scale. As stated above, to be effective, a regulator must be efficient and consideration must be given to the most efficient use of support services and how smaller professions are regulated. Larger regulators must be able to remain effective and all changes must be kept under regular review. From a public perspective, the quantity of regulatory bodies is far less important than the quality of the service that they provide.

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

The College suggests that there should be relevant synergy between the professions that would be regulated together. This includes professional groups not currently regulated, e.g. Physicians Associates which although working closely with doctors are not medically trained or qualified – their regulatory needs may differ.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

Yes: this is a key function of a regulatory body.

Q9: What are your views on the role of mediation in the fitness to practise process?

Mediation could be useful in some circumstances but must be conclusive and with clear and finite timelines. It has the potential to reduce unnecessary stress from the fitness to practice process where this is appropriate. There must be well defined thresholds for fitness to practice cases, and where there is a clear case to answer then mediation would not be appropriate.

Q10: Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance?

To an extent. PSA standards should be retained for serious misconduct cases; however this is not their only role. There should more preventative upstream interventions to reduce emphasis on the end stage of fitness to practice performance.

Q11: Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

Yes, the College supports this proposal.

Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

We support this as the regulator has a clear role in this regard to revalidation. The regulator will need to work closely with the relevant professional associations including the medical Royal Colleges, as the standards setters who have produced extensive specialty guidance which sets out requirements for content and amount of CPD to make it relevant in each specialty/discipline.

The regulator must maintain a robust system of standard setting and quality assurance of all providers of post graduate education. Specialist royal colleges, as independent experts, are in an ideal position to set curricula, recommend standards and contribute to quality assurance but may require resourcing to support the regulator in this way.

Q13: Do you agree that the regulators should work more closely together? Why?

Yes: there should be a forum for sharing good practice and for closer cooperative working.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

Yes, generally the College supports these proposals, particularly where efficiencies will be realised to improve the quality of service provided and therefore the effectiveness of the regulators. However it is important to ensure that joint working does result in benefits and does not add to bureaucracy.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

Yes: where verified, formal data is available to share, providing this is fully compliant with data protection law and processes. This has the potential to identify potential harm earlier. Informal or “soft information” should not be solely used to inform decision making.

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

There should be flexibility in the system to allow this, however there must be consistency across the regulators in general terms of operation.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

No. External, parliamentary scrutiny is a key part of maintaining public confidence in our regulatory system. Regulation is currently a reserved issue to the UK Parliament and while this is the case, it is important that the professional competence of health professionals is consistent on a UK wide basis to protect quality standards for all patients across the UK. Therefore the UK Parliament remains the key and only institution to which the regulators should be accountable.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

No. The College does not see that the inclusion of executive members of councils would bring any discernible benefits in terms of accountability. Employees of a regulatory body are answerable to the council without the need to explicitly name them as members of council. It is more important that the governing councils reflect public and professional expertise.

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

No, the College does not consider this to be a practical suggestion, largely due to the number of different employers involved. It is also important to note that the councils of regulatory bodies are there to consider professional standards of care, not delivery of service and there are other avenues for these discussions to be furthered.

Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

Yes, this seems reasonable, particularly for new regulatory bodies as they are established. Existing regulatory bodies must also continue to assure the UK Parliament, through for example an annual report, of their continuing ability to be effective and fit for purpose.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

The business case for reform should explicitly identify the efficiencies expected and where the resulting gains could be reinvested.

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?
- an increase
- a decrease
- stay the same
Please explain your answer and provide an estimate of impact if possible.

If the proposed changes effect improvements in efficiency then our Fellows and Members will benefit, particularly from a more proportionate approach to Fitness to Practice cases.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

There is little published evidence that the additional focus on regulation is (as yet) contributing to patient safety and quality of care. KPIs for regulatory bodies should be agreed in advance and openly published, e.g. volume of complaints, severity of complaints and time to resolution.

Q24: Do you think that any of the proposals would help achieve any of the following aims:
- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?
- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?
- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?
If yes, could the proposals be changed so that they are more effective?
If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

The College considers that fee structure should be examined in this regard: it must be proportionate and equitable. There should be recognition of full and part time working; gender balance and the structures must be proportionate to income.