

# **Enabling Excellence**

Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers

Analytical Strategy for the Command Paper

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## Overall Purpose

1. The Command Paper, 'Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers' sets out the Government's proposals for how the system for regulating healthcare workers in the United Kingdom and social care workers in England should be reformed to sustain and develop the high professional standards of our health and social care staff and to continue to assure the safety of those using services and the public.
2. The Coalition Agreement set out a clear agenda for reducing bureaucracy and the regulatory burden. We aim to ensure that the system of professional regulation is proportionate, accountable, consistent, transparent and targeted, in line with the Government's wider policy on regulation.
3. The aim of the Command Paper is to achieve that balance: ensuring that professional regulation is proportionate and effective, imposing the least cost and complexity, consistent with securing safety and confidence for patients, service users, carers and the wider public.
4. The strategy contained within the Command Paper consists both of policies that will be implemented through the Health and Social Care Bill 2011 (the Bill) and areas where further exploration is required. A new 'Enabling Excellence through Professional Standards' programme will be established at the Department of Health (the Department) to implement those policies.
5. This document also sets out our proposals for public engagement for those areas where further exploratory work is required to gauge the views of health and social care professionals, patient and service users and the public on the most appropriate way of achieving our proposals. The Secretary of State for Health (England) will commission the Council for Healthcare Regulatory Excellence (CHRE) to provide advice on a number of aspects of the policy proposals set out in 'Enabling Excellence'. Where advice is commissioned from the CHRE, we will expect the CHRE to engage with a wide range of stakeholders in drawing up its advice to Ministers.

# Assessing the Impact of the Command Paper

## Overview

6. The professionalism, skills, values and commitment of those working in health and social care are the critical underpinning for safe, effective and respectful care in our health and social care services. In England, as the NHS White Paper, 'Equity and Excellence' puts improved outcomes of patients at the heart of what the NHS does, it is essential that the regulatory arrangements for health professionals continue to support that objective.
7. The current system of professional regulation helps set high standards of education and training, conduct and ethics and enables action to be taken to remove unsuitable workers in the rare cases when things go wrong. However, the regulatory framework is complex, requiring continuous Government intervention to keep it up to date, and compulsory and centralised statutory regulation is not necessarily the most effective or efficient way of ensuring high quality care.
8. The Command Paper, 'Enabling Excellence', contains a number of policies that are interlinked and mutually reinforcing, some of which are committed to and are being implemented through the Bill, which was introduced in Parliament on 19 January 2011. This paper gives an overview of, and provides links to, the detailed analysis of those policies that will be delivered through the Bill and sets out the rationale for those areas that the Government intends to explore further.
9. Those policy proposals set out in 'Enabling Excellence' which are being taken forward within the Bill and analysed in its accompanying Impact Assessment are:
  - reforms to the CHRE to provide it with greater independence and to make it self funding;
  - reforms to the powers of the CHRE to enable it to establish a system for accrediting voluntary registers of healthcare workers across the UK and social care workers in England;
  - reforms to enable the health professions regulatory bodies and the CHRE to assist the Privy Council in making appointments to regulatory bodies (in light of proposals to abolish the Appointments Commission);
  - abolition of the General Social Care Council (GSCC) and transfer of the function of regulating social workers in England to the Health Professions Council (HPC);

- changes to the powers of the CHRE to provide it with functions in respect of the regulation of social workers; and
- abolition of the Office of the Health Professions Adjudicator (OHPA).

10. With regard to the OHPA, following a full public consultation, the Government has concluded that the function of adjudicating in fitness to practise cases for doctors could be delivered more proportionately by other means and therefore has decided to abolish the OHPA. Whilst not an arm's-length body (ALB), the OHPA is similar in nature and the impact of its abolition has therefore been included in summary in the Public Bodies annex.
11. Those policies to which we are already committed are not discussed in detail here as the Health and Social Care Bill 2011 Impact Assessment has already been published. However, links to that Impact Assessment and associated documents are available below, along with a summary of each policy.
12. Impact assessments are not contained in this document for those policies we describe as 'exploratory', as further work will be undertaken in these areas and more evidence gathered and analysed in respect of each policy proposal. The impact assessments for those policies will be developed and published as required in line with this strategy.

## Policy Overview and Analytical Framework

13. This section outlines the analytical framework for assessing the impact of the Command Paper and directs the reader to where the benefits, costs and risks in respect of each policy, to which we are already committed, can be found.
14. The Department is committed to delivering the policies which are being taken forward within the Bill as set out in paragraph 1.4 above.
15. This Analytical Strategy does not claim any cost savings or benefits for these policies as these are already included in the Health and Social Care Bill 2011 Impact Assessment. That Impact Assessment includes details of each of the policies we are committed to delivering.
16. In addition to those policies to which the Government is already committed in the Bill, the Department also intends to undertake further exploratory work in respect of the following:
  - Simplification of the professional regulatory framework through a Law Commission Review;
  - The establishment of a statutory register of authorised herbal medicine and traditional Chinese medicine practitioners;
  - A more effective system for undertaking checks on language knowledge of primary care practitioners;
  - The potential for passing the costs of infraction fines on to the health professions regulatory bodies where they are responsible for the UK being infringed for breaches of their statutory obligations as competent authorities under Directive 2005/36/EC;
  - Enhancing the accountability of the regulatory bodies to the UK Parliament and an increased role for the CHRE in enabling greater scrutiny by Westminster and the Devolved Administrations through its annual performance review process;
  - Requirements for healthcare professionals to hold insurance or indemnity; and
  - Revalidation in respect of:
    - Doctors; and
    - Non-medical healthcare professionals.
17. We will also ask the CHRE for advice on:

- Whether there is scope to deliver efficiency savings across the health professions regulatory bodies; and
- The scope and potential design of a scheme set out in regulations to enable the CHRE to investigate complaints regarding the policies of the health professions regulatory bodies.

18. Impact assessments will be developed where necessary as part of this process (including in respect of any new proposals developed in light of the CHRE advice) and will be published alongside relevant consultations, final decisions or implementation proposals, including for example secondary legislation.

## **Reforms to Professional Regulation in the Health and Social Care Bill 2011**

19. The Department is committed to implementing the policies described in this section and impact assessments are published alongside relevant consultations and as part of the Health and Social Care Bill 2011 Impact Assessment.

20. The Health and Social Care Bill 2011 Impact Assessment is available via the following link:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm>

### **Council for Healthcare Regulatory Excellence (CHRE): Independence, self-funding and enabling accreditation of voluntary registers**

21. At present the CHRE has a range of functions in respect of the regulation of health professionals. As part of its functions it scrutinises and oversees the work of the nine regulatory bodies that set standards for training and conduct of health professionals.

22. The report of the Department's review of its ALBs 'Liberating the NHS: Report of the arm's-length bodies review' signalled the Government's intention to remove the CHRE from the ALB sector, and make it self-funding through a levy on the regulators it oversees (subject to Parliamentary approval). This is in line with the long-standing principle that regulators should be independent of both the Government and those they seek to regulate. The Government's view is that there is merit in extending this principle to the body tasked with overseeing the work of the regulatory bodies. The funding of the CHRE through a statutory, compulsory levy on the nine health professions regulators will be the mechanism for achieving this. Removing grant-in-aid funding from the CHRE will also free up resources for frontline NHS care.

23. At present, the Privy Council appoints the Chair of the CHRE, with three non-executive members appointed by the Secretary of State and three non-executive members appointed by the Devolved Administrations. To underline the CHRE's independence from Government, in future (subject to Parliamentary approval of the proposals in the Health and Social Care Bill 2011) all Secretary of State appointments of non-executive members to the CHRE will become Privy Council appointments. However, Ministers in the Devolved Administrations will each retain their power to appoint one non-executive member to the CHRE.

24. Privy Council and Secretary of State appointments to the CHRE are currently delegated to the Appointments Commission. However, 'Liberating the NHS' announced the abolition of the Appointments Commission from April 2012. We are therefore proposing to take powers in the Bill to enable the CHRE to support both the Privy Council and Ministers in the Devolved Administrations in making appointments to its board. Similarly, the CHRE will also be given powers to assist the Privy Council in making appointments to the councils of the health professions regulatory bodies.
25. The report also proposed that the CHRE's remit be extended to enable it to set standards for and to quality assure voluntary registers of healthcare workers in the UK and social care workers in England. For some groups working in the health and social care sectors, statutory regulation may be a disproportionate response to the level of risk to the public. An assured system of voluntary registration would seek to enhance standards of professional and occupational competence and provide clear standards of expected conduct, but without the need for compulsory statutory regulation.
26. Finally, the CHRE's remit will be extended so that it has the power to oversee the bodies which regulate, or may in future regulate, social workers and social care workers in England in addition to its existing functions in respect of healthcare regulation across the United Kingdom. The CHRE's new powers will ensure consistent scrutiny of the regulatory arrangements for both sectors. The CHRE will therefore quality assure the professional regulation of social workers (England only), which is to transfer from the General Social Care Council to the Health Professions Council, a body which is already overseen by the CHRE. To reflect the CHRE's extended remit, it will be renamed as the Professional Standards Authority for Health and Social Care (subject to Parliamentary approval).
27. An analysis of the impact of these changes is included in the Health and Social Care Bill 2011 Impact Assessment.

### **Appointments to Regulatory Bodies**

28. Currently the Appointments Commission, acting under directions from the Privy Council, appoints members of the governing councils of the health professions regulatory bodies. However, 'Liberating the NHS' announced that, from April 2012, the Appointments Commission is to be abolished (subject to Parliamentary approval). When the Appointments Commission is

abolished, responsibility for making appointments to the regulatory bodies will revert to the Privy Council.

29. The Government considers that there is a need to retain an open, independent, competence-based system of appointment and we will discuss options for achieving this outcome over the longer term with the Devolved Administrations, the Privy Council, the regulators, the CHRE and other interested parties.
30. In the meantime, to enable appointments to be made once the Appointments Commission is abolished, there are new powers proposed in the Bill enabling the Privy Council to arrange with others, including the regulatory bodies themselves and the CHRE, to assist the Privy Council in making appointments to the regulatory bodies.
31. We propose that, in the short term, the Privy Council will ask each of the regulatory bodies to manage their own recruitment process, in line with good practice guidance, including any guidance to be issued by the CHRE. The regulators would be free to arrange for a third party to manage this process. The CHRE would provide the regulatory bodies with guidance on good practice in appointment processes, stressing the need for an independent mechanism, and would work with all the regulators to agree common standards. The CHRE would subsequently provide appropriate assurance that good practice in the appointments process has been followed. Privy Council would then make the appointment.
32. An analysis of the impact of these changes is included in the Health and Social Care Bill 2011 Impact Assessment.

### **Abolition of the General Social Care Council and transfer of its functions in respect of the regulation of social workers in England to the Health Professions Council**

33. 'Liberating the NHS' announced the Government's intention to abolish the General Social Care Council (GSCC) and transfer its functions in respect of the regulation of social workers to the Health Professions Council (HPC), which is to be renamed the Health and Care Professions Council (subject to Parliamentary approval). The policy aims and objectives are to:
  - ensure public safety and confidence in the regulation of social workers is maintained through an organisation that is both effective and sustainable;
  - support the delivery of the aims of the ALB Review to significantly reduce administration costs and simplify the ALB sector; and

- make social worker regulation independent of Government.
34. This will move the regulation of social workers in England out of the ALB sector to make it operationally and financially independent of government. Making social worker regulation in England independent of government and placing it with a proven successful and efficient regulator is in keeping with the Hampton Principles and should lead to better regulation and improved public safety. Additionally, social worker regulation in England will in future (subject to Parliamentary approval) benefit from scrutiny and quality assurance by the CHRE.
35. An analysis of the impact of these changes is presented in the Health and Social Care Bill 2011 Impact Assessment.

### **Abolition of the Office of the Health Professions Adjudicator (OHPA)**

36. The OHPA is an independent public body which was established under the Health and Social Care Act 2008 on 25 January 2010. Although not an ALB of the Department of Health, because it had not yet become operational (and thereby self-funding) the OHPA has a call on public funds and is therefore included in the Health and Social Care Bill 2011 Impact Assessment. The problem under consideration was whether the creation of the OHPA was the most appropriate solution to address concerns that there should be greater independence of the adjudication process from the investigative process within the fitness to practise procedures operated by the General Medical Council (GMC) and the General Optical Council (GOC). Provisions were included within the Health and Social Care Act 2008 to create the OHPA to undertake the adjudication process instead of the GMC and the GOC.
37. The objective was to provide a system of adjudication for fitness to practise cases that was more independent of the prosecuting body. However, having reviewed the case for the OHPA, the Coalition Government is not persuaded that the creation of another body is the most appropriate and proportionate way forward. In the consultation paper 'Fitness to Practice Adjudication for Health Professionals: Assessing different mechanisms for delivery' we consulted on our preferred option which was to enhance the current GMC processes, rather than proceeding with the establishment of the OHPA. For the reasons given in our response to that consultation, we have decided to proceed with the preferred option. A final Impact Assessment has been published alongside the Government's response to that consultation. The response to the consultation and other associated documents, including the Impact Assessment, are available via the following link:

[http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_122293](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293)

38. Provisions to repeal legislation pertaining to the OHPA are included within the Bill. The Impact Assessment accompanying the Bill assesses the changes to the Department of Health's public bodies, including OHPA, and the associated costs and benefits.

## **Exploratory Work**

39. The Department intends to explore further the policies described below in this section. Impact assessments will be developed as options for implementation are identified and assessed and will be published alongside relevant consultations, final decisions or implementation proposals (including, for example, secondary legislation). All of these proposals will be subject to assessment of their affordability.

### **Simplification of the regulatory framework - Law Commission Review**

40. Reforms in 2008/09 to the governance of the health professions regulatory bodies ensured that they became independent of both of the professions they regulate and of Government through independent competence based appointments and parity between the numbers of registrant (i.e drawn from the profession or professions being regulated) and lay members. However, they remain dependent on Government and Parliament for legislation to modernise their statutory responsibilities, powers and structures. Constraints on Government resources mean that only the most pressing issues can be acted upon and the usual process for making these changes takes around two years.
41. This poses restrictions on the regulators' ability to respond and adapt their processes to changing circumstances. It also has the potential to hamper them in meeting their duties to protect the public and fulfil their statutory obligations in the most cost-efficient and effective way. Consequently, regulators are frequently unable to make important changes that would allow them to:
- improve their performance;
  - work less bureaucratically;
  - contain and ultimately reduce costs to registrants; and
  - respond more fairly and effectively to public and professional concerns.
42. The Government intends to explore the most effective way of creating an enabling legislative framework, by asking the Law Commission to review the existing legislative framework and develop a single draft Bill to cover all existing UK health professions subject to statutory regulation. This will make use of the specific expertise and skills of the Law Commission, which was established by Parliament with the express purpose of keeping legislation up to date. The

Law Commission Review will be a simplification review with the objective of creating a system that would provide greater autonomy to the regulatory bodies in deciding how best to meet their statutory duties. It will investigate ways of creating an enabling legislative framework that would allow the regulators freedom to develop their own rules and procedures. Parliament would continue to set in statute the outcomes required from the regulatory bodies, but it would be for individual regulators to decide on, and take responsibility for, how those outcomes were delivered.

43. The Law Commission will work with each of the Devolved Administrations to develop proposals and make comparisons with similar legislatures around the world (e.g. Canada, Australia, New Zealand) and the EU. It will prepare detailed impact analysis (including costs and benefits) on central government administration, the regulatory bodies and registrants. Any proposals will be published for consultation and a detailed impact assessment will be prepared at that point.
44. The Department is currently discussing the terms of reference for this review with the Law Commission and, once agreed, those terms will be published on the DH and Law Commission websites.

### **Regulation of Herbal Medicine and Traditional Chinese Medicine Practitioners**

45. European Directive 2004/24/EC (amending 2001/83/EC) will come fully into force in April 2011 and will make the supply of unlicensed manufactured herbal medicines bought in from a third party illegal. It is likely that very few manufactured herbal medicines intended for the herbal practitioner market will have a product license in the future and therefore to do nothing would mean the supply of those herbal medicines would be prohibited.
46. However, it is possible for authorised healthcare practitioners to continue to supply unlicensed medicine through the use of an exception (a derogation) within the Directive, by the creation of a suitable Article 5.1 'specials' framework by the Medicines and Healthcare Products Regulatory Agency (MHRA) Directive 2001/83 EC. As herbal medicine and traditional Chinese medicine practitioners in terms of applying herbal medicines are currently not subject to any form of professional regulation, the Government intends to explore the introduction of an appropriate form of statutory regulation for practitioners so that registered practitioners could legitimately continue to supply these products in the UK.
47. Rather than placing limitations on the supply of these products, regulation in this area would enable the continued existence of a market. This would ensure that there would be continued

consumer choice of legally supplied products through herbal or traditional Chinese medicine practitioners. Equally, it would allow those businesses and individuals engaged in the market to continue trading.

48. Should a decision to introduce new regulations be taken, we will seek evidence of the effect this change will have on practitioners and the consumer as part of a consultation on any draft regulations. An impact assessment is currently being prepared to support the process of policy development and we would expect to publish it alongside any future consultation.

### **Language checks for European Economic Area migrant GPs working in the UK**

49. At present, Primary Care Trusts (PCTs) perform the function of checking the language skills of migrant GPs working in the UK, prior to them taking up positions within the NHS, under the Performers List Regulations 2004. However, subject to the successful passage of the Bill, PCTs will be abolished. The Government intends to explore how the proposed new NHS Commissioning Board could oversee a system for undertaking checks on language knowledge of primary care practitioners, and at the same time address the historic lack of consistency in the application of checks by PCTs.
50. The analytical work in this area will involve work with PCTs to understand the costs and benefits of the present system, the likely future demand for language testing, and how this might translate into a system operated by the NHS Commissioning Board.

### **Infraction Fines**

51. Infractions (or infringement proceedings) are the legal process by which the European Commission takes a Member State to the European Court of Justice (ECJ) for breach of its obligations under European Union (EU) Law. The process is governed by articles 258 and 260 of the Treaty on the Functioning of the European Union (TFEU).
52. The European Commission is responsible for bringing legal proceedings against Member States when it considers that they are not complying with EU law. Where a Member State breaches EU law, the European Commission may instigate infraction proceedings. The purpose of these proceedings is to seek compliance from Member States. Ultimately, the Commission may refer

the matter to the ECJ and, where the court rules that a Member State is in breach, the Member State will have to comply with the court's judgment or face the prospect of a fine.

53. A breach of EU law will typically fall into one of three categories:
- non-notification (or non-communication) to the Commission of the national transposing measures;
  - incorrect or inadequate implementation of the directive; and/or
  - incorrect application of EU Law.
54. Under the current arrangements, the Government (therefore the UK taxpayer) is liable for any fines resulting from any regulatory failure to comply with EU legislation and there is therefore little incentive for the regulatory bodies to ensure compliance.
55. The Government therefore intends to explore the scope for taking legislative powers to enable it to seek a contribution towards any fines arising from infractions for incorrect or inadequate implementation of EU law that has been caused by failings on the part of the regulatory bodies in respect of their functions as competent authorities for certain purposes under Directive 2005/36/EC.
56. The analytical work in this area is expected to involve work with regulators to understand the costs and benefits of any proposals.

### **Accountability of regulatory bodies**

57. Reforms in 2008/09 to the governing arrangements to the regulatory bodies ended the practice of registrant (i.e. professional) council members being elected by the registrants and all registrant and lay members are now appointed through an open, competence based process. Whilst this has removed any perceived bias in respect of professional members acting for their 'electorate', the Government is concerned that this has not been replaced with sufficiently effective alternative accountability arrangements. Giving greater autonomy to the regulators, as outlined in the White Paper, needs to be balanced by a commensurate strengthening of their public and parliamentary accountability.
58. The aim is to strengthen the public and parliamentary accountability of the regulators to ensure that confidence in their impartiality, effectiveness and ability to protect the public continues. The regulatory bodies currently produce annual reports and accounts which are laid before the UK. Through discussions with Parliament and the Devolved Administrations, the Government intends

to explore whether additional mechanisms might be introduced to enable each legislature to hold regulatory bodies to account. This might include looking at enhancing the role of the CHRE in enabling greater scrutiny of the regulatory bodies through its annual performance review process.

59. This work will explore the benefits to the public, patients and registrants of enhancing the accountability of the regulatory bodies, and the costs and benefits of increasing the role of Parliament (including Devolved Assemblies/Parliaments) or that of the CHRE in this process. A detailed impact assessment will be developed together with any proposals.

### **CHRE - Efficiency Review**

60. The combined cost of the health professions regulatory bodies exceeded £200 million a year in 2009/10. The direct costs of the system fall largely on registrants themselves, through annual retention fees which they are required to pay. However, as these fees are partially tax-deductible, and also feed into pressure on pay in the NHS, there is also a significant cost to the taxpayer.
61. Fees vary between regulators. This variation can be largely attributed to economies of scale, due to the different volumes of registrants that each regulator has, with registrants of smaller bodies sharing a larger proportion of the cost. However, scale is not the only factor, with the business models of each regulator and the constraints of their individual legal frameworks suggesting that there is likely to be scope for significantly greater efficiency in all regulatory bodies.
62. The Government is clear that one way of reducing the costs of regulation would be to merge regulators into higher volume organisations. However, it also recognises the disruption and professional concern that centrally imposed consolidation can cause. As an alternative to such structural change, the Government therefore intends to explore how reductions in cost might be delivered through alternative means.
63. The analytical work will commence with the Government commissioning the CHRE to lead a sector wide review of the cost-efficiency and effectiveness of each regulator, with a view to identifying significant costs savings. The costs and benefits of the options identified by the CHRE with the potential to deliver savings will inform an impact assessment. A decision on how to proceed will be taken in light of this analysis.

## **CHRE - Powers to investigate complaints regarding regulators' policies**

64. The CHRE already assesses and reports on the performance of each regulatory body on an annual basis and it also reviews all of their final fitness to practise decisions to consider whether they might be too lenient. However, existing powers to investigate complaints about the regulatory bodies are not yet fully in force. Although the regulators themselves have complaints procedures in place, there is anecdotal evidence that legitimate concerns that might be raised about the policies or approach of a regulator could benefit from further external scrutiny.
65. While needing to avoid the CHRE becoming overwhelmed by complaints from individuals who simply disagree with valid decisions reached by the regulators, the Government intends to explore how such powers might be used to address concerns, promote best practice and benefit both the public and the regulators. The Government therefore intends to commission the CHRE to provide advice on detailed proposals for commencing Section 28 of the NHS Reform and Health Care Professions Act 2002 by the end of 2011.
66. The commission will ask the CHRE to:
- consult with the regulators regarding the proposals;
  - advise how a scheme of regulations might be drawn up to achieve the desired policy outcomes; and
  - set out a suggested timetable for implementation (taking into account the need perhaps for individual regulators to consult on changes, etc.).
67. Ministers will consider the CHRE advice and a detailed impact assessment will be developed together with any proposals in light of its advice. We would anticipate consulting on draft regulations under Section 28 of the NHS Reform and Health Care Professions Act 2002 in due course.

## **Insurance or Indemnity**

68. The Government believes that, on the rare occasions when patients, the public, or service users suffer harm through negligence on the part of a registered healthcare professional, redress should be available to them.

69. The recent ‘Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional’ concluded that making insurance or indemnity a statutory condition of registration is the most cost effective and proportionate means of achieving the policy objective.
70. Proposals for legislative changes will be introduced in light of the final wording for the Patients’ Rights in Cross-Border Healthcare Directive (which may include provisions relating to indemnity) at the next appropriate opportunity. Decisions regarding the need for consultation will be taken at that point and any consultation will be accompanied by a full impact assessment.

## **Revalidation**

### **Medical**

71. Proposed mechanisms for medical revalidation are currently being piloted to get a clear understanding of the costs, benefits and practicalities of implementation. The Government announced in June 2010 that piloting would be extended for a further year in England to allow systems to be streamlined and robust cost-benefit analysis to be carried out. Subject to a test of readiness in the summer of 2012, revalidation will be rolled out in late 2012. An impact assessment is being produced, which will be informed by the outcome of pilots.
72. The Responsible Officer Regulations came into force on 1 January 2011. Responsible officers will play a key role in supporting doctors to improve the quality of care they provide and in ensuring that prompt action is taken to protect patients where concerns arise about the practice of individual doctors. An impact assessment relating to this work has already been published and is available at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH\\_117786](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_117786)

### **Non-Medical**

73. For the non-medical health professions, there is a wider spectrum of risk to be addressed by different regulators and a ‘one size fits all’ approach would not be appropriate. The Department, with the agreement of the Devolved Administrations as appropriate, has therefore asked each of the health professions regulatory bodies which are accountable to Westminster to continue to

develop the evidence base that will inform proposals for revalidation over the next year. For those professions where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services from additional central regulatory effort on revalidation, the Government will agree with the relevant regulators, the Devolved Administrations, employers and the relevant professions the next steps for implementation.

## Public Engagement Strategy

74. ‘Enabling Excellence’ sets out a statement of the Government’s intent in respect of regulation of health and social care professionals. As such, the Department is not proposing to conduct a general public consultation on the proposals, which are at different stages of development. Rather we intend to commission advice from the CHRE on a range of issues and the CHRE will be asked to engage stakeholders as part of the process of drawing up its advice.
75. In light of advice from the CHRE and the outcome of exploratory work by the Department on a range of issues we will consider the need for further public consultation. Specific consultation will be undertaken on any proposed regulatory changes. The table below sets out our proposed approach to public engagement on the key proposals within the Command Paper.

### Summary of Public Engagement Strategy

<b>Issue</b>	<b>Approach to consultation</b>
CHRE reforms	Included in the Bill – no consultation on new powers, but the CHRE will be asked to seek the views of stakeholders as part of the process of advising Ministers about implementation of a system of accredited voluntary registration.
Transfer of GSCC functions to HPC	Included in the Bill – no consultation on intention to transfer, but HPC will establish a professional liaison group to ensure that there is meaningful engagement with social workers about the new standards of proficiency.
Abolition of OHPA	This has been consulted on already and we will not consult further following publication of the Command Paper.
Voluntary registration of social workers	We will ask the CHRE for advice on the options here (e.g. a joint register of health and social care support workers in England, various registers to common standards, etc.) before taking a view on the preferred approach. We will then decide whether further consultation is necessary.
Efficiency savings	The CHRE will be asked to provide advice to Ministers and to engage with stakeholders as part of the process of doing so. We will then decide whether further consultation is necessary.
Commencement of Section 28	The CHRE will be asked to provide advice to Ministers and to engage with stakeholders as part of the process of doing so. Following this we would anticipate a formal DH consultation on any draft regulations.
Governance and accountability of the regulators	The CHRE will be asked to provide advice to Ministers and to engage with stakeholders as part of the process of doing so. We will then decide whether further consultation is necessary.
Proposals for language	We will consider the need for formal consultation once final

checks overseen by the NHS Commissioning Board	proposals are worked up.
EU infraction fines	We intend to consult on this in due course prior to any regulatory changes.
Law Commission Review	The Law Commission of England and Wales will work with its counterparts in Scotland and Northern Ireland to develop proposals which will be published for consultation alongside a detailed impact assessment.
Register of herbal and traditional Chinese medicines practitioners	The policy intention has been consulted upon already. However, there will be a further consultation by DH on any draft regulations in due course.
Indemnity	Implementation will be taken forward in light of the final wording of the proposed Directive on Patients' Rights in Cross-border Healthcare (which may include provisions relating to Indemnity). Any regulatory changes will be subject to consultation.
Medical revalidation	The GMC has undertaken a public consultation on their plans for medical revalidation. We will take a view on whether there is a need for any further consultation on this issue following completion of pilots.
Non-medical revalidation	The Department has asked each of the regulatory bodies for non-medical healthcare professionals to continue to develop the evidence base that will inform their proposals for revalidation over the next year. A view on the need for consultation will then be taken once there are substantive proposals.

## **Conclusion**

76. While there is no formal public consultation on ‘Enabling Excellence’, should you have any comments or views, on either the Command Paper ‘Enabling Excellence’ or this strategic impact assessment, then you are welcome to send these to:

**Professional Standards Division  
Department of Health  
Room 2N11  
Quarry House  
Leeds  
LS2 7UE**

77. The Department will consider any comments it receives regarding this document or the Command Paper more generally.
78. If you want the information that you provide to be treated as confidential, please be aware that, under the Freedom Of Information Act, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to the Department when submitting your comments why you regard the information you have provided as confidential.

## List of Acronyms Used

ALB	Arm's Length Body
CHRE	Council for Healthcare Regulatory Excellence
DH	Department of Health
ECJ	European Court of Justice
EU	European Union
GMC	General Medical Council
GOC	General Optical Council
GSCC	General Social Care Council
HPC	Health Professions Council
MHRA	Medicines and Healthcare Products Regulatory Agency
OHPA	Office of the Health Professions Adjudicator
PCTs	Primary Care Trusts
SofS	Secretary of State
TFEU	Treaty on the Functioning of the European Union
The Bill	The Health and Social Care Bill 2011
The Command Paper	Enabling Excellence – Autonomy and Accountability for Health and Social Care Workers