



The Royal College of **Pathologists**

Pathology: the science behind the cure

Response from the Royal College of Pathologists to Promoting Professionalism, Reforming Regulation Consultation

The Royal College of Pathologists' written submission

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1. About the Royal College of Pathologists

The Royal College of Pathologists (RCPATH) is a professional membership organisation with charitable status. It is committed to setting and maintaining professional standards and to promoting excellence in the teaching and practice of pathology. Pathology is the science at the heart of modern medicine and is involved in 70 per cent of all diagnoses made within the National Health Service. The College aims to advance the science and practice of pathology, to provide public education, to promote research in pathology and to disseminate the results. We have over 10,000 members across 20 specialties working in hospital laboratories, universities and industry worldwide to diagnose, treat and prevent illness.

The following is a collation of responses from Fellows of the Royal College of Pathologists to the request for input to the Consultation from the Department of Health on Promoting professionalism, reforming regulation. Where differences of opinion appeared no attempt has been made to reconcile the differences. As a result, what may superficially appear to represent contradictions within the document actually represent areas of variable opinion.

2. Response

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?

1.1 We are concerned that many of the proposals, including this one, give increased power and responsibility to the PSA. The consultation documentation provides no explanation of how the PSA is constituted and regulated and why the public should have confidence in its ability to undertake these tasks. Appointment of its members by the Privy Council provides some evidence of independence from the government of the day, but this is unlikely to be perceived by most members of the public as full independence.

The importance of independence is stressed in para.1.3 of the consultation document. These principles need to be applied to the PSA too.

The concept of independence is challenged within the consultation document by repeated statements (such as in para 1.2) that Parliament is 'responsible' for regulation.

The PSA is probably well placed to take on this specific role, but only after the PSA itself has been subjected to a review and has established a more transparent method of public scrutiny of its work.

1.2 No objection to the PSA advising Government on which groups are regulated – as long as it remains impartial.

1.3 No. I do not agree with the consultation's assertion in paragraph 2.2 "*While the UK governments recognise that the PSA powers to accredit voluntary registers, it is not believed this will create a conflict of interest*". There is no explanation of how the governments have come to this conclusion and, as the PSA already accredits organisations covering practitioners not regulated by law, I believe there will be a conflict of interest and, as such, it is not appropriate for the PSA to take on the role of advising the UK governments on which groups of professionals should be regulated.

1.4 No. Why is there no COI for the PSA, whereas there is for the HCPC? (Role of both organisations potentially much overlap).

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?

2.1 The criteria seem reasonable, but their interpretation is inevitably subjective and will require consistent good judgement.

2.2 Criteria for oversight make sense – if applied across the board.

2.3 The criteria suggested by the PSA are very broad and, while admirable, don't seem to be limited to professional groups. They need to define what are the professional groups and who does this cover? Reading the risk of harm key areas, it seems to me that carers for the elderly and infirm should also be included as they go into someone's home and the patients are often vulnerable. However, it is not clear if they intend to expand registration to this group (maybe they should, given the responsibility of the job and the vulnerability of the patients, but it is such a low paid job and a struggle to fill vacancies that an extra financial burden to carers may be a death knell to recruitment).

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?

3.1 Yes, although this should be a careful process not a knee-jerk reaction.

It should be recognised that there are many groups which will clamour for the professional status provided by regulation. This includes groups with practises that are not supported by sound scientific evidence (such as homeopathy). Pressure to obtain such legitimisation should be resisted. Therefore the criteria should include an assessment of the efficacy of the work undertaken; 'professions' that do not genuinely produce benefit to the public should not be offered the legitimacy implied by regulation.

3.2 The chiropractic and osteopathic councils can be disbanded. These groups should be subject to market forces, not professional regulation.

3.3 No opinion one way or the other.

3.4 Not particularly. The largest regulators (GMC, GDC, GNC) have well established mechanisms for the regulation and monitoring of their respective professions and there is no obvious societal need for reassessment; were there to be a need, there are already mechanisms in place to address such issues (i.e. the introduction of revalidation as a response to concerns regarding practitioners would be a good example).

3.5 I would like to see the GMC being more supportive of doctors but I'm not sure if this would be captured, or indeed felt to be appropriate in such reform.

3.6 We clinicians have a good enough system... I do not wish it to be put at risk by putting us together with the managers.

3.7 Doctors and nurses are already the best trusted professions...so a change in regulation may just cause more work and more confusion.

Which groups should be reassessed as a priority? Why?

3.8 Those identified as ‘outliers’ in number of regulated professionals or cost of regulation. The smaller professions regulated within HCPC.

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

4.1 Probably potentially useful, but this is a very reactive approach and reliance on this method alone seems unlikely to produce the desired benefits.

4.2 Prohibition orders are a useful way of checking if someone has been barred from practicing a specified profession and would make it easier to check up before employing someone if they are no longer fit to practice.

4.3 I think there is benefit in having a specialist regulator for individual professions as they are likely to have a more consistent and reproducible approach to setting standards of practice and determining when an individual practitioner’s performance falls below this level. However, recognising that there are certain professions whose practices are reliant on the absence of objective evidence to justify their interventions, having an ‘independent’ body prohibiting an individual from undertaking such work may be a safer option as there would be no organisational (professional) bias towards their specialty. (I’m largely thinking of complementary medicine.

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

5.1 Yes, but **the information provided in the consultation document is not subjected to a rigorous statistical analysis and some of the conclusions are very questionable.** For example, Diagram 3 plots the relationship between size of a regulator and unit costs. It is interpreted as showing a decrease in costs with increasing size, with a plateau above 300,000 registrants. This conclusion is unjustified because there is only one regulator with more than 300,000 registrants. Conversely, it could be argued that if two very small outliers (GCC and GOsC, both with fewer than 6,000 registrants) were excluded, the graph would show no relationship between size and unit cost at all.

5.2 Yes, there should be fewer regulatory bodies. However, why reduce from 9 to 3 or 4? Why not take the opportunity to reduce to a single regulatory body which can have separate departments focussing on specific professions? This would deliver an even more consistent approach to regulation as delivering savings (as per paragraph 2.12)

5.3 Only for complementary therapy (forming one regulatory body and broadening their remit to encompass more practitioners). It would be nice if there had to be an evidence base for practice and would help the NHS prioritise funding in this rather small area.

5.4 Although there is an NHS code of conduct for senior managers this is too generic and I do not see this being applied in any great capacity and would fully welcome manager regulation, having regard for and demanding ethical practice and decision making based on informed consultation.

5.5 My general suspicion is that if there are economics of scale involved in this PSA initiative it is likely to lead to inappropriate decision making in regard to individual practitioners – treating apples and pears as just fruit.

5.6 I think the regulatory bodies need to be separate for different health professionals otherwise the regulatory body will be a huge monolith and lack focus and targeted oversight.

5.7 Should dentists, medics, nurses and scientists be regulated in the same way and by the same organisation? - yes.

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

6.1 Difficult to evaluate, as the case in the consultation document is not made convincingly (see above).

It is also relevant that the costs of regulation are currently paid by those who are regulated, so the failure of this consultation explicitly to comment on the preferences of those who pay for the system is an omission.

6.2 Advantages: Easier admin and public transparency.

Disadvantages: Loss of professional identity.

6.3 I cannot see any disadvantages of having fewer regulatory bodies, as long as each profession has specialised staff with a remit for a given professional group, not a general call centre approach, so applicants can speak to someone knowledgeable about their professional status.

6.4 I think health professionals making patient decisions and dealing with patients needs to be regulated by the same organisation, to ensure they are all working to the same standards.

6.5 Dentists, medics, nurses and scientists be regulated in the same way in general term but more appropriate by relevant professional bodies. However these bodies could be regulated as different sections of the same organisation.

6.6 Have you considered putting forward a suggestion in this HMG consultation regarding no-fault reporting of incidents and near-misses (equally important), similar to the airline industry on the basis that

a) it removes much of staff fear that encourages cover-ups and

b) it encourages more complete incident reporting and

c) it encourages more thorough thinking around the incidents and a team approach to it

d) it works (in improving quality and safety)?

If this were adopted, it wouldn't matter if one body oversaw it.

6.7 I don't agree that everyone should be accountable to the same regulatory body: each professional group has very specific professional requirements and should have separate regulatory bodies. All regulatory bodies should be INDEPENDENT of Government, DH and NHS, and should have appropriate professional and lay members. AS well as ensuring protection of patients, the regulatory bodies should determine standards and the knowledge base (but should not be involved in regulating training). They should also protect the regulated members from malicious and vindictive behaviour and should support members with health issues.

6.8 I have two main concerns about this issue. Firstly, the proliferation of unregulated low level practitioners in the hospital service often going under the generic title of health care assistants. Mortuary technicians are also unregulated at present. Secondly, it is now possible to be appointed as a Local Authority Director of Public Health without being on the register of any of the health professions. That surely is a matter that needs addressing.

6.9 I believe a single organisation is better to regulate the NHS in regards, doctors, nurses, dentists, etc. A divided organisation would be more fractured and difficult to manage.

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

7.1 The HCPC provides an example of a regulator that covers many different professions, but I am not convinced that it provides an example that should be emulated.

7.2 Combine opticians and dentists. Combine GPhC with PSNI. Disband GCC and GosC.

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

8.1 Yes.

8.2 All bodies to have full range of powers.

8.3 Yes, all regulatory bodies should be given full range of powers. Would be easier to legislate and manage if there was only a single regulatory body.

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

9.1 The option should be available.

9.2 Mediation: useful as a feature of an inquisitorial approach rather than the finality of a fitness to practice procedure.

9.3 Mediation may be a helpful way forward in cases where fitness to practice is questioned but may not be irrevocable. Currently, due to the serious consequences on an individual's career that are likely resulting from an investigation into fitness to practice, I think there is a reluctance to report colleagues to the HCPC (in our profession). An intermediate process of mediation through the remit of a regulatory body may help have issues resolved if they have gone beyond internal management and mean that referrals may be considered more readily.

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

10.1 I am not convinced that the case for this has been made. The full question in the body of the consultation document adds "...and consider the wider performance of the regulators". It is unclear what is meant by 'the wider performance', or who decides what it means. This needs much greater clarity.

10.2 Agree that PSA's standards should place less emphasis on 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?

11.1 No. To be tried twice for the same offence is dubious legal practice. The phrase "... *it is considered...*" begs the question of who considers it so. The tabloid press? Politicians? If the regulators are well regulated they should be trusted to do their job. The regulator should be held to account if they make unjustified or otherwise bad decisions whether these are to the disadvantage of the public or to the disadvantage of the individual or institution being regulated.

11.2 Yes. The PSA should retain powers to appeal regulators' fitness to practice decisions in court.

11.3 How often has this occurred since the powers were established in 2002? I think the right to appeal the regulators' decision from either side (too harsh or too lenient) is important.

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?

12.1 'Supporting professionalism' is a vague concept. Regulators should focus on ensuring that those joining a profession have achieved the required standard, and that those who are in a profession maintain that standard. The temptation to extend the role into oversight of training and educational processes should be resisted.

12.2 Agree regulators have a role in supporting professionalism, and should continue to work with Royal Colleges and professional societies to maintain and develop standards.

12.3 Yes, I think regulators have a role in supporting professionalism. They have published standards but it would be helpful if they published more detailed guidance with examples about how achieving each standard could be evidenced.

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

13.1 Regulators should work more closely to ensure common standards for values & behaviour.

13.2 Yes. In most cases this is probably a better solution than merging them.

13.3 Regulators should work more closely together. Ultimately, there should be only a single regulatory body, removing this need.

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?

14.1 A 'single set of generic standards' may be a good idea, but will have to be broad and vague; 'profession-specific needs' will be numerous, and the division into two types of standard risks generating confusion and perhaps devaluing the profession-specific standards.

A single adjudicator will have difficulty coping with the breadth of activities involved; from brain surgeons to art therapists?

Single back-office functions might improve efficiency, but this is far from certain and (depending on the definition of a 'back-office function') it could become a route towards inappropriate external influence, e.g. via finance. As the costs of the regulators are paid by those who are regulated, this is a decision for them to make, not the Government.

14.2 Areas for joint working: shared online register and joint back-office working, BUT NOT: single set of generic standards, single adjudicator.

14.3 The areas suggested are the rights ones to encourage joint working.

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

15.1 Yes. I am less convinced that merging regulators will automatically improve communications.

15.2 Agree – data sharing between regulators would identify potential harm earlier.

15.3 Data sharing may help identify potential harm earlier. However, it would have to be relevant data between relevant regulators. As individuals are rarely able to practice as qualified in different professions, it is unlikely to be a common occurrence. Any cases of fraudulent claims of qualification should be identified and dealt with accordingly.

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

16.1 Yes, subject to appropriate oversight. As noted above:

We are concerned that many of the proposals, including this one, give increased power and responsibility to the PSA. The consultation documentation provides no explanation of how the PSA is constituted and regulated and why the public should have confidence in its ability to undertake these tasks. Appointment of its members by the Privy Council provides some evidence of independence from the government of the day, but this is unlikely to be perceived by most members of the public as full independence.

The importance of independence is stressed in para.1.3 of the consultation document. These principles need to be applied to the PAS too. The concept of independence is challenged by repeated statements (such as in para 1.2) that Parliament is 'responsible' for regulation.

The PSA is probably well placed to take on this specific role, but only after the PSA itself has been subjected to a review and has established a more transparent method of public scrutiny of its work.

16.2 Agree – regulatory bodies need greater flexibility to set own operating procedures.

16.3 Yes, but if regulatory bodies set their own operating procedures, what would be the governance processes overseeing and agreeing any changes to be necessary?

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?

17.1 No, because this is likely to increase the potential for divergent standards in different parts of the UK.

17.2 Disagree that regulatory bodies should be more accountable to the devolved countries, which would be unnecessary duplication.

17.3 Regulatory bodies should be equally accountable to each of the UK governments, as professionals are able to move and work freely in any of the UK regions. However, the 4 UK governments must agree any procedures so regulatory bodies do not have different reporting standards etc for each region.

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?

18.1 Councils of regulatory bodies should have both non-exec and executive members.

18.2 Yes, councils of regulatory bodies should comprise both non-executive and executive members for good governance.

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?

19.1 No. Regulation should be independent of employers (as the consultation document itself says at para. 1.3).

It is one of the great strengths of medical appraisal and revalidation that it is focussed on benefit for the patient, not the employer. Employing bodies argued against this during the development of medical revalidation and were rightly resisted.

19.2 No. Views of employers should not be reflected on regulatory council bodies. Employers have government performance targets as a higher priority than public safety.

19.3 Yes, the views of employers should be better reflected on the councils. A member of the council should be the link to employers and professional bodies so the impact of any changes in regulation on each profession can be communicated to the regulators' board.

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?

20.1 Regulators do not themselves "produce and sustain" fit to practice individuals; they ensure that others are doing so. This should not change. With that caveat, regulators should surely already be doing this?

20.2 Agree that each body should be asked to set out proposals about how they will produce and sustain fit to practice and fit for purpose professionals.

20.3 Not sure it is the remit of the regulatory body to ensure they produce and sustain fit for purpose professionals. Is this not the responsibility of accredited training course providers and employers? The involvement of another organisation may make the systems even more complex.

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?

21.1 If the concept of professional self-regulation is regarded as anachronistic (as this document clearly indicates is the case), then the practice of those who are regulated paying for the cost of regulation is surely also anachronistic?

What is meant by 'invested upstream to support professionalism'? We should guard against regulators having 'mission creep'. Their role should be limited to ensuring that those joining a profession have achieved the required standard, and that those who are in a profession maintain that standard. The temptation to extend the role into oversight of training and ongoing educational processes should be resisted.

21.2 If payment by those who are regulated is to continue, then those who pay should be consulted on this point.

21.3 Savings from the reforms should both be passed back as fee reductions and invested to support professionalism.

21.4 Potential savings should be passed back as fee reductions as professionals already carry a large burden of fees with not only their regulator, but also several relevant professional bodies as well. However, on P27 table 5, there is a very stark differential between the total operating cost per registrant. The governments need to make sure that rationalisation of regulatory bodies does not result in increased fees for some professions in order to obtain a mean registration fee for all professions; reduction in operating costs for some should not be subsidised by those currently being regulated by a more efficient or less costly (in terms of investigation procedures) body. If some professions naturally have a higher cost to their fitness to practice investigations, I suggest these professions continue to have higher registration fees to cover this. I.e. Single regulatory body but with differential fees for the different professions depending on complexity.

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.

22.1 No change, no comment.

22.2 Proposed changes will probably not affect cost or benefit for my organisation.

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

23.1 The potential for improvements is set out in the document, but their realisation will depend heavily on the quality of implementation.

23.2 Changes will contribute to public protection and patient safety via common standards and transparency.

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?

24.1 No comment.

24.2 Impossible to judge the effect on Equality and Diversity.

Extra comments:

1. P5 *"Future workforce strategies will focus on the development of innovative health and care roles and ensuring that professionals have the flexibility to work across traditional boundaries"*. Do they anticipate as part of this overhaul that there will no longer be protected titles?

P17 para 3.3 *"...for example through the use of undertakings..."* What does this mean? Not clear from the context

P31: annual retention fee for HCPC listed as £90, whereas table 5 on p27 lists the HCPC operating cost at £76 per registrant. Is the regulatory body making a £14 profit per registrant? If so, where is this money going? Investment into education, training, standards and governance are already listed in the breakdown of the operating costs.

2. This an interesting proposal however I think there may be a better way of tackling the problem.

The fragmented approach to the investigation of problems leads to multiple investigations and long drawn out investigations.

There are complaints from people subject to these processes is that they are used to victimise whistleblowers and as part of bullying of employees.

A better approach would be to investigate the clinical failings of individuals only as part of a comprehensive system failure analysis.

This is the approach adopted by the Air Safety investigators. It works on the assumption that most people do not come to work intending to do a bad job.

They government needs to decide whether it wants to learn from incidents or blame individuals.

The Air Safety investigators have achieved legal privilege for their investigations to encourage a full disclosure of what happened.

What I would suggest is there is one investigatory framework for clinical incidents and underperforming staff it covers everyone involved in the process and the system failures that lead to the problems.

The outcome of this process is then feed to the regulatory bodies with a recommendation on what sort of action should be taken against individuals.

The only cases that the regulators should have power to determine is cases referred to them involving unacceptable personal conduct e.g. criminal convictions such as assault.

The regulatory bodies should be reduced to supporting professional development and maintaining a register of qualified people.

NHS managers should also be a regulated profession.

This could be done by a smaller number of bodies.