Consultation on the future shape of the Accredited Registers programme

Contents

1. Introduction

Purpose of this consultation

1.1 This consultation document seeks views on the Professional Standards Authority's proposals on the future shape of the Accredited Registers programme, which provides assurance for roles in health and social care that are not required to be regulated within the UK. It asks whether the programme is still an appropriate regulatory mechanism for the occupations it covers, and if so, how it can be improved. It also seeks views on how to ensure that the programme becomes self-funding in 2021/22, given that the Authority cannot continue to subsidise the programme.

1.2 You can respond to this consultation paper by completing the Word document available here and submitting it by email to:

ARconsultation@professionalstandards.org.uk

Please return your response to us by **18 February 2021**.

Our role and the Accredited Registers programme

The Professional Standards Authority

1.3 The Professional Standards Authority helps to protect the public through our work with organisations that register and regulate people working in health and social care.

1.4 We are an independent UK body. Our role and duties are set out in the Health and Social Care Act 2002 (as amended). There are three main areas to our work:

- We oversee the work of the ten statutory bodies that regulate health and social care professionals in the UK
- We accredit registers held by non-statutory registering bodies of health and care professionals
- We aim to improve regulation by providing advice to UK government and others, conducting/commissioning research and promoting the principles of right-touch regulation.

The Accredited Registers programme

1.5 In 2011, Coalition Government set out its strategy for reforming the system for regulating healthcare workers in the UK and social workers and social care in England through its Command Paper *Enabling Excellence*[1].

1.6 *Enabling Excellence* set out the rationale for a system of assured voluntary registration to be developed for professionals and occupational groups which are not currently subject to statutory professional regulation. This was envisaged as a proportionate way of ensuring that voluntary registers operate effectively and to high, common standards. It was intended to give assurance to employers and the public.

[1] https://www.gov.uk/government/publications/enabling-excellence-autonomy-and-accountability-for-health-and-social-care-staff

1.7 To create this new system, in 2012 the Authority was given new powers and duties to accredit voluntary registers. The Health and Social Care Act[2] sets out that our functions under this legislation are:

1) to promote the interests of users of health care, users of social care in England, users of social work services in England and other members of the public in relation to the performance of voluntary registration functions,
2) to promote best practice in the performance of voluntary registration functions, and
3) to formulate principles of good governance in the performance of voluntary registration functions and to encourage persons who maintain or operate accredited voluntary registers to conform to those principles.

1.8 The Act sets out at Section 25G that in order to accredit a voluntary register, the Authority may assess it against criteria that it sets and publishes. A voluntary register under this definition is a register of people working in health care roles in the UK, and social care in England, who do not have to be regulated in order to work.

1.9 On its introduction, the Department of Health and Social Care (DHSC) agreed to provide funding whilst the programme was established, provided it achieved self-funding status by April 2021. For 2020/21, we have received approximately £162,000 from the DHSC, which constitutes around 30% of our forecasted overall income. After fee income which constitutes around 50% of our income currently, this leaves a deficit of approximately 20% of £90,000 for 2020/21. The Authority has limited reserves and cannot continue to rely on DHSC subvention or subsidise the programme from its own resources. It is therefore essential that the programme achieves financial viability in the 2021/22 financial year and beyond for the Authority to be able to continue to run it.

1.10 Today, the programme covers 26 registers and over 90,000 practitioners. This includes approximately 60 different types of occupation including counsellors, psychotherapists, health scientists, public health practitioners, complementary therapists and homeopaths. Practitioners work in a variety of settings including independent practice, the NHS, education, and voluntary organisations.

This consultation and our strategic review of the programme

1.11 In June 2020, we announced[3] the Terms of Reference for a strategic review of the Accredited Registers programme:

1) To consider to what extent the programme has achieved the aim for it, set out in *Enabling Excellence* and the Health and Social Care Act 2012, and if not, why not.
2) To identify funding options to achieve financial sustainability.
3) To consider the scope of the programme and whether the Authority's criteria for inclusion or exclusion of occupations are sound.
4) To identify how the Accredited Registers programme might achieve the traction it needs so that more benefit from the assurance it provides.

[2] https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[3] https://www.professionalstandards.org.uk/news-and-blog/latest-news/detail/2020/06/08/the-authority-announces-a-strategic-review-of-the-accredited-registers-programme

5) To make recommendations for the future shape of the Accredited Registers programme.

1.12 This is the first time since the programme was introduced in 2012 that we are undertaking a thorough review of its effectiveness. The programme has not achieved the levels of recognition and use which were originally envisaged. We think it is timely to consider whether it is an appropriate way of overseeing the occupations within its scope, and if so, how it can be improved.

1.13 There have also been significant changes in the wider health and social care environment since the programme was introduced. These represent an opportunity for the programme to make a greater contribution within the wider health and social care systems – but only if voluntary assurance is wanted and supported by Government, the NHS, social care, the independent sector and patients and service users. This is especially pressing given that the progamme must become self-funding in the 2021/22 financial year.

1.14 This consultation tests the programme's original design principles and sets out proposals for a fundamental re-design so it can better meet the needs of employers, patients and the public. 'Success' will mean that accreditation becomes a routine requirement for employers and is a greater driver of the choices of patients and the public. It will also require us to successfully implement a funding model that allows the programme to cover its operating costs, and obtain external funding to develop a new model.

1.15 If this is achieved, then the programme will be able to support health and social care services for patients and service users, by promoting public trust and confidence in the regulation of the registers that it accredits. This in turn will allow it to make a greater contribution to the wider health and social care system. It will do this by supporting greater integration of some of the occupations it already covers, and of which Covid-19 has further exacerbated the need for, such as within mental health. It will also support the development of the new and expanding workforces where there is an identified need.

1.16 Information about the Accredited Registers programme can be accessed through our website[4]. Information about our Standards for Accredited Registers, application process, and annual renewals can be found on our Resources page[5].

2. Identifying the problem

This section sets out the issues we have identified with the current approach from our own research and feedback from stakeholders during the initial stage of our strategic review.

Original design principles

2.1 When the programme was introduced in 2012, it was the first system of independent oversight for many of the occupations within its scope. The design

[4] https://www.professionalstandards.org.uk/what-we-do/accredited-registers
[5] https://www.professionalstandards.org.uk/what-we-do/accredited-registers/resources

principles which underpin the current approach reflect this, and state that the programme should:

1) Ensure that any restrictions developed through the creation of the Standards, or the operation of the programme, would reflect the potential risks of harm to the public.
2) Not unfairly or unnecessarily restrict the market by creating monopolies. It should be open to any eligible register, including those relating to the same occupation.
3) Be affordable for applicants, and not price small registers out of the market, making it open to registers clustering under umbrella organisations.
4) Should not set the education and training requirements for entry onto a register.
5) Would not make any judgement about the effectiveness of any therapy or health or care practice.

2.2 While we are still committed to the first of these design principles, we think that changes to the way that health and social care are delivered, and our own learnings from the first eight of years of the programme, mean we should consider a fundamental re-design of all other aspects.

Overview of the current process

2.3 To be eligible for accreditation, organisations must meet Standard One of our Standards for Accredited Registers[6] ('the Standards'):

2.4 Standard 1: the organisation holds a voluntary register of people in health and/or social care occupations.

2.5 The Authority determines whether an occupation is 'health care' by having regard to the definition of health care set out in the National Health Service Reform and Health Care Professions Act 2002, section 25E (8):

2.6 ''Health care' includes: all forms of health care for individuals, whether relating to physical or mental health; and procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition."

2.7 We have not to date accredited any registers of unregulated social care workers within England. However, the revised criteria set out later in this document would require that the role is used or being introduced within the social care sector. This could include new roles that act as a bridge between health and social care, such as social prescribing.

2.8 Organisations that meet these definitions may apply for accreditation. They are required to submit evidence to demonstrate how they meet each of the Standards. The Standards are set at the bar for good practice, and organisations are required to meet all of them to be accredited. A Panel, comprising senior members of the Authority's staff and occasionally Board members, assesses this evidence and makes a final decision on whether to grant accreditation. The assessment does not include any consideration of the effectiveness of the occupation or treatments provided by registrants.

[6] https://www.professionalstandards.org.uk/docs/default-source/accredited-registers/standards-for-accredited-registers/standards-for-accredited-registers.pdf?sfvrsn=cc2c7f20_4

2.9 Once accreditation has been granted, to be maintained it needs to be renewed on an annual basis. Accredited Registers must provide evidence to demonstrate that they continue to meet the Standards, as set out in the Annual Review Process Guide[7].

2.10 'Recommendations' can be issued to Accredited Registers, where opportunities to improve practice and enhance the operation of the register are identified. 'Conditions' are issued when a Standard has not been met. A Condition sets out the requirements needed for the Accredited Register to meet the Standards, within a set timeframe. In cases of serious or ongoing concerns, a Panel may determine that accreditation of a register should be suspended or removed. If serious concerns are raised, we will not wait for the annual assessment but undertake an in-year review.

Understanding the problem we are seeking to solve

2.11 The wider regulatory system is complex. The Authority has set out the rationale for a more coherent system of regulation, through our 2016 paper Regulation Rethought8. The problem in its broadest form is that the current system of multiple regulators and registers is difficult for patients and the public to navigate, and that oversight is not always proportionate to risk.

2.12 A key question to address is whether voluntary assurance can be effective in protecting patients and the public within the current system.

2.13 Since its introduction the programme has been successful in raising the standards of the current Accredited Registers, in fostering collaboration between registers and in improving complaints processes for the public. The improvements that have been made by Accredited Registers in response to issuing Recommendations and Conditions are set out in our reports of their annual renewals.

2.14 However, our review of voluntary assurance schemes in other sectors shows that to be effective, they must have high levels of coverage, robust requirements, high levels of awareness and be recognised and used by the broader systems in which they operate.

2.15 Our own research of patient and public perceptions, undertaken in March this year, shows that there is low awareness of the programme (and of regulation generally); and that recommendations from family and friends, rather than accreditation, is the key driver of their choices. Further, the programme's coverage of around 90,000 practitioners is a small proportion of the two million unregulated roles in health and social care. This means that while patients and service users who choose practitioners from Accredited Registers will have derived benefit from the improvements made since the programme's introduction, these benefits do not extend far enough and remain largely hidden.

2.16 The original intention was that employers would consciously choose to use practitioners on an Accredited Register, because it had been quality assured by the Authority. This would benefit patients and service users even if they remained unaware of the programme itself. However, adoption by employers has been low.

[7] https://www.professionalstandards.org.uk/docs/default-source/accredited-registers/guidance-documents/annual-review-process-guide.pdf?sfvrsn=e5c7220_10
[8] https://www.professionalstandards.org.uk/docs/default-source/publications/regulation-rethoughtd6c718f761926971a151ff000072e7a6.pdf?sfvrsn=48557120_0

The main reasons we have identified so far for this are lack of consistency across education and training standards, and accreditation not going far enough to offer assurance, particularly in occupations considered higher risk.

2.17 Although Accredited Registers ensure that they do not accept onto their register any practitioner who has been removed from another Accredited Register, or by any of the statutory regulators overseen by the Authority, the voluntary nature of the programme currently cannot prevent an individual from practising independently in an occupation which is not regulated by law. This can undermine confidence by employers and may fall short of what patients and the public would expect from a system of assurance.

2.18 The definition of health and care is broad and as a result the occupations that can fall within the scope of the programme are wide-ranging. They include practitioners carrying out invasive procedures such as clinical physiology or non-surgical cosmetics; those working in the psychological therapies such as counsellors, psychotherapists, and play therapists; hands-on therapists such as those practising in foot health and sports massage; health scientists and complementary therapists of various types including homeopaths. Although we have not yet received applications from registers of unregulated social care roles, those within England are eligible under the current legislation.

2.19 The Authority has to date taken the view that it is preferable to include a broad range of the occupations being used by patients and service users. It has also considered that it is not equipped to assess whether therapies practised within occupations are effective. Some people think we should not include occupations for which there is no firm evidence that they work, even if the public choose to use them. They are concerned that being accredited by the Authority lends credibility to therapies that are not evidence based. Our research earlier this year indicated mixed views amongst the public in this area.

2.20 Many Accredited Registers have told us that while they value accreditation, the process itself can be burdensome. The application process can be lengthy, and the paperwork involved in the cycle of annual reviews is not always proportionate to the risk. This limits our ability to invest time in activities to raise awareness, audit, and to support new registers to meet the Standards for accreditation. Many share employers' concerns that unsuitable practitioners can continue to provide services to the public even if they are no longer on an Accredited Register, and that they cannot be prevented from doing so within the current legislative remit for the programme.

2.21 The section below sets out a vision for the future which seeks to address these problems and ensure an effective system of voluntary assurance. However, unless there is a collective desire for these problems to be solved and a willingness across the system to work together, the Authority will not be able to deliver the changes required to achieve this.

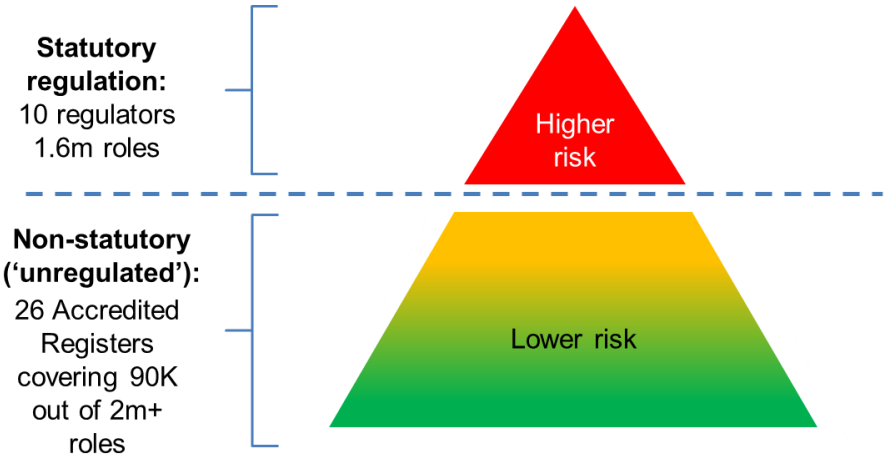
3. Our vision for the future

3.1 We want to make the system of assurance for unregulated roles simpler to use; become a driving force in patient, service user and employer choices; and be proportionate to the risk of the occupations that it covers.

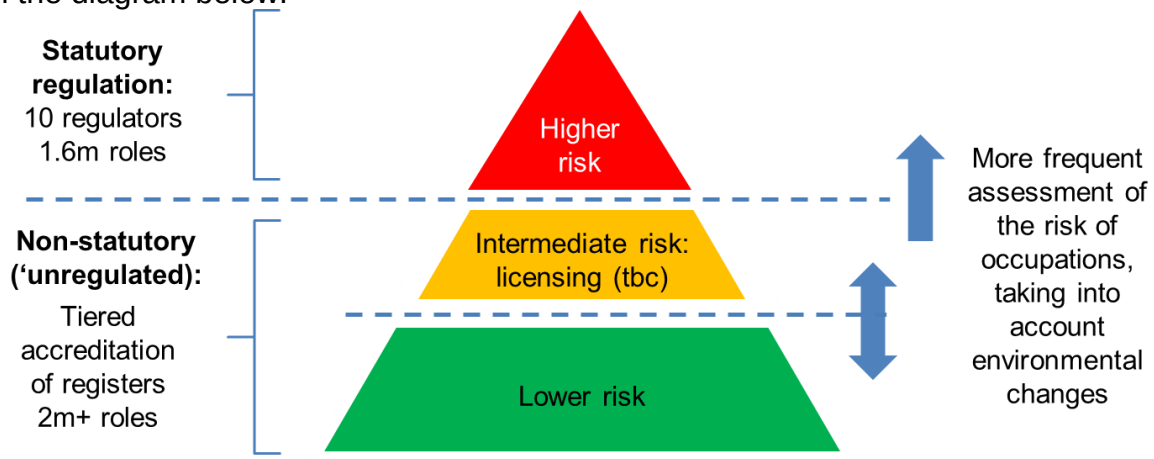
3.2 We think that to achieve the original aims set out for it, the programme should be used to:

a. Support the delivery of NHS healthcare and social care workforce plans in England, NI, Scotland and Wales. This includes contributing to personalised care for patients and the Covid-19 recovery in health and social care. The pandemic has highlighted the need for greater integration of health and social care, and of the value of mental health care delivered by unregulated roles.
b. Become a requirement for employers using healthcare practitioners in unregulated roles in the UK, and social care in unregulated roles in England
c. Support innovation and be able to respond quickly to change. This is an advantage that voluntary assurance has above statutory regulation.

3.3 Key to the success of this will be determining the appropriate level of oversight for occupations within health and social care. The diagram below shows how the current programme sits within the broader regulatory system:



3.4 Our proposals for the future would introduce a tiered system according to risk, and mechanisms for routinely assessing the level of risk posed to the public, as set out in the diagram below:



3.5 Our review of research and stakeholder feedback so far has identified the key features for a revised system of voluntary assurance that could achieve the above:

- The ability to provide oversight for the new and expanding unregulated roles which have been identified as workforce priorities by setting minimum requirements for new registers for their first cycle of accreditation.
- Greater consistency of standards for individual occupations, including for education and training, so that there is less variability of competence and disciplinary outcomes.
- Greater assurances for the 'intermediate risk' occupations, such as the ability to exclude unsuitable practitioners, for example through licensing.

3.6 To succeed, the programme needs to gain the visible confidence and support of Government, the NHS, the social care system, employers, Accredited Registers and their registrants, and patients and the public. It requires careful preparation. For this reason, we propose a phased approach to change.

3.7 In 2021/22, we intend to revise the accreditation process to make it more proportionate to risk. This will include a longer assessment cycle for registers that consistently meet our Standards. We also propose to introduce new accreditation criteria, to allow us more control over which organisations and occupations are eligible to apply. We will introduce a new fees model, to achieve financial sustainability.

3.8 From 2022, we propose to work closely with stakeholders to identify common standards and frameworks for individual occupations. Where there are already common frameworks for education and training in development, such as for the psychotherapies and foot health, we will support this and look to encourage replication across other occupations. This will also lay the foundations for registers of occupations to potentially form 'umbrella' bodies which would allow for a simpler system for patients and the employers and greater consistency of standards for entry, complaints handling and disciplinary outcomes.

3.9 This means that in the future, there could be fewer organisations accredited by us – but that those organisations would be working closely with the professional bodies within the sector, whose members we anticipate would largely be eligible for registration with the umbrella body. Examples of organisations already working in this way include the Academy for Healthcare Science and the Complementary and Natural Healthcare Council.

3.10 In the long-term this could pave the way for a single register in the future, as envisaged in *Regulation Rethought* if Government considered that desirable. Although originally envisaged as a single register for all health and social care roles, this body could provide oversight for the intermediate occupations only, or for all non-statutory registers. It could be introduced with, or without, a system of licensing. Licensing would involve the body being able to grant permits for practice. However, in keeping with our *Right-touch* approach, if we found that the introduction of other measures such as common frameworks for occupations was enough to address the potential risks to the public, then we would not introduce further regulation. A key part of the future vision is the ability to be responsive to changing environments. In parallel with these changes to Accredited Registers, if supported by Government and other stakeholders, we would develop our own mechanisms for assessing the risk of occupations.

3.11 We recognise that this vision goes beyond that set out in *Enabling Excellence* and may require legislative change to deliver. Setting out clear steps for change will

make sure that while our overall aims are rooted in our *Right-touch* approach, we don't wait to make changes that will better protect patients in 2021/22.

4. Proposals for change and consultation questions

Overall approach

4.1 Research we have reviewed to date has shown that voluntary systems of assurance can be effective when they have clear requirements, are recognised and used by the wider system in which they operate and have good levels of awareness and coverage.

4.2 Although the Accredited Registers programme has not yet achieved this, improvements to all registers accredited since its introduction indicates that it can be effective, if we are able to address the problems identified and secure employer use and recognition.

4.3 All of the registers that have been accredited to date are of health care occupations. However, our legislation allows for us to register unregulated social care roles within England and we think this programme could be useful.

4.4 Our own research undertaken in March 2020 into perceptions of the programme by patients and the public indicates that recommendations from family and friends are currently the key drivers of choice and there are very low levels of awareness. However, our aim is for accreditation to be a greater factor in patient choice in the future. This is particularly important for accreditation to be effective in protecting patients and service users in the independent sector, where a significant proportion of the current Accredited Register Practitioners currently work.

Question 1: Do you agree that a system of voluntary registration of health and social care practitioners can be effective in protecting the public?

Proposals for change in 2021/22

Eligibility and accreditation criteria

4.5 Our approach to date has been to include a wide range of healthcare occupations within the programme, on the basis that this will best protect the public who choose to use them. We have focused our Standards and assessment approach on the four functions that help protect the public: standards for registrants, registration, education and training and complaints handling. Also included are standards on governance, and information for the public.

4.6 There are differing perspectives on how best to 'promote the interests' of users of healthcare. The NHS has a framework for making decisions about which treatments and interventions to routinely commission. Some of the treatments which patients choose outside of the NHS will fall outside of this framework. Unless a treatment is determined to be illegal, there may be no system of oversight, if the registering organisation is not accredited by the Authority.

4.7 However, we also recognise the risk that some treatments can be chosen as alternatives, rather than complementary to, conventional treatments. For patients

whose conditions require medical supervision, this may result in harm. In cases where the public understands accreditation to mean that the Authority endorses the occupation and treatment itself, this could offer false assurance and exacerbate this risk. Our research in March this year found that those who were positive about Accredited Registers felt disappointed after learning that accreditation did not take into account efficacy of treatments. This suggests that the current approach might not go far enough to meet expectations of patients and the public.

4.8 To only accredit occupations where there is a recognised evidence base for the treatments provided, or which are used by the NHS, may exclude occupations that nonetheless are considered to have benefits for patients and users of social care. It may exclude new roles which have not had time to establish an evidence base. However, we believe it is important for the public to have clear information about the limitations of treatments. Our current approach therefore is to require organisations to be clear about the extent to which there is or is not evidence about effectiveness.

4.9 It is also important that inclusion of a register or occupation does not bring the rest of the programme into disrepute, increase the potential for harm to patients or damage public confidence in health and care. There can be a tension between the register's role in public protection, and serving professional interests, when a voluntary register is held by a professional association. We mayneed to make a clearer assessment of whether the register is putting public protection first, in the future.

4.10 To date, the registers we have accredited are of health care occupations. However, our legislation allows for us to register unregulated social care roles within England. This is an area in which we are keen to expand our provision.

4.11 To allow the Authority to have greater discretion over what is included within the scope of the programme, we could introduce criteria, for example:

a. The occupation or role is used or introduced within the NHS or equivalent other public or independent healthcare sector body
b. The occupation or role being used or introduced within the social care sector
c. The occupation or role is used for personalised care by patients with the support of their healthcare provider
d. The occupation or role is used independently by the public to support their health and wellbeing
e. The inclusion of the occupation or role will maintain confidence in the accreditation programme
f. Government and/or other public authorities support its inclusion in the programme.
g. The register's aims and objectives are focused primary on public protection.

4.12 These criteria would help the Authority to assess the benefits of the occupation or role, against the potential risks. For example, if our initial consideration of the register found that its policies and objectives were focused primarily on professional interests above public protection, we would be concerned that this could lead to policies and processes which did not adequately protect patients. This could present risks such as treatments being offered as alternatives to medical supervision for serious conditions.

Question 2: How do you think the Authority should determine which occupations should be included within the programme? Is there anything further you would like us to consider in relation to assessing applications for new registers?

Proportionality and risk

4.13 Currently, we review a register's accreditation annually. We also review the performance of the statutory regulators we oversee annually. We are proposing to change to a longer review cycle of potentially three to five years.

4.14 We think that considering a longer cycle for renewal of accreditation would be proportionate, and comparable with other schemes of accreditation that we considered during the initial phase of our strategic review. Registers do not usually make significant changes to their processes on an annual basis. However, we would undertake periodic checks of Accredited Registers in between full renewal assessments and increase our audit activities where necessary to ensure compliance.

4.15 Although assessments to date have focused on the governance and systems in place to deliver the key functions of Accredited Registers, there have been instances where it has come to our attention that Registers have not taken quick enough action to deal with non-compliance of their registrants. We believe that greater capacity to audit would enable us to provide greater assurance.

4.16 In addition, we have to date set the bar for the Standards at the level of good practice. Whilst we think this is appropriate, we are considering introducing 'minimum requirements' for new Accredited Registers for their first cycle of assessment. These would align to the current set of Standards but allow for improvements to be made within the first cycle of assessment. If registers did not meet the higher standards after this point, then accreditation would be removed. We think this would be more proportionate and allow for new and developing registers to demonstrate improvements from accreditation. We would introduce a fee for pre-assessments for new registers that takes into account size and number of occupations registered, the extent to which we need to consider evidence of eligibility in accordance with the new criteria. We may also charge a fee for additional audit activities if it is needed within the review cycle.

Question 3: Do you think that moving from an annual to a longer cycle of renewal of accreditation, proportionate to risk, will enable the Authority to take a targeted, proportionate and agile approach to assessment? Do you think our proposals for new registers in terms of minimum requirements are reasonable?

Effectiveness of occupations

4.17 The Standards for Accredited Registers[9] were last updated in 2016. We are not proposing to revise the whole set of Standards, although as noted above we may look in the future to include more specific requirements for education and training.

4.18 One area we are considering more immediate changes is in relation to the effectiveness of therapies and treatments offered by the occupations registered. One of the original design principles stated that the programme 'Would not make any judgement about the efficacy of any therapy or health or care practice.' This

[9] https://www.professionalstandards.org.uk/docs/default-source/accredited-registers/standards-for-accredited-registers/standards-for-accredited-registers.pdf?sfvrsn=cc2c7f20_4

was on the basis that patients and service users should be free to choose treatments that they feel are in their best interests, if they are not harmful or illegal. We also recognise the importance of personalised care within the NHS, which aims to empower patients to make decisions about their treatment, in partnership with their healthcare provider.

4.19 However, the Authority has been criticised for accrediting registering bodies of treatments that are not offered by the NHS, and for which there is little evidence base. Some have expressed concern that accreditation of the registering body by the Authority may confer that the treatment is effective.

4.20 This means we need to think about how to ensure accreditation gives confidence in practitioners. The key issues for us to consider are:

- What accreditation means is clear to the public, and whether it confers an endorsement of the effectiveness of the therapy.
- Whether it is our role to require evidence of the efficacy of treatments

4.21 Our role in monitoring and enforcing compliance of registrants so that they only work within their defined scope of practice.

4.22 The Standards which are relevant to these issues are:

- *Standard 6 - The organisation demonstrates that there is a defined knowledge base underpinning the health and social care occupations covered by its register or, alternatively, how it is actively developing one. The organisation makes the defined knowledge base or its development explicit to the public.*
- *Standard 8b – The organisation bases its standards of competence upon its defined body of knowledge.*

Question 4 - Has accreditation been interpreted as implying endorsement of the occupations it registers? Is this problematic? If so, how might this be mitigated for the future?

Evidence base

4.23 We will consider the feedback from Question 4 above, in our approach to efficacy in the future. There are three broad options for addressing these issues currently under consideration:

Option 1 – knowledge base

4.24 Under this option we would maintain our current requirement at set out under Standard 6 for a defined knowledge base.

4.25 By ‘knowledge base’, we mean a collection of information that supports an understanding of what an occupation does, and how it should be used. Unlike ‘evidence base’, it does not seek to answer definitive questions such as effectiveness. Rather, it is the body of knowledge that the Accredited Register has drawn on to develop its own standards and requirements for registrants.

4.26 We could also consider further strengthening this requirement by:

a. Setting a time limit for the Accredited Register to have developed a defined knowledge base, or

b. Requiring a defined knowledge base, rather than the development of one, to meet the Standard.
c. Setting our clearer requirements for what is 'recognised' knowledge, such as peer-reviewed research papers.

Option 2 – evidence base

4.27 This option would involve greater requirements for Accredited Registers to set out the evidence base for occupations they register.

4.28 We recognise that perspectives on evidence base evolve, and that it is not the role of the Authority to determine which treatments should or should not be chosen by patients and the public. Within this option we would determine that where there is only very weak evidence, it would not be in the best interests of patients and service users for the registering body to be accredited as this may imply effectiveness.

4.29 An example of the type of evidence framework we might use, with strongest first:

- Systematic review or meta-analysis of randomised controlled trials
- At least one randomised controlled trial
- At least one well-designed and controlled study without randomisation
- At least one well-designed quasi-experimental study, such as a cohort study
- Well-designed non-experiential descriptive studies, such as comparative studies, correlation studies, case-controlled studies and case series
- Expert committee reports, opinions and/or clinical experience of respected authorities

4.30 We would require Accredited Registers to demonstrate the evidence base for registered occupations, and to advise us on any changes through the assessment of renewal. We may also set up an external Advisory Group to make recommendations on decisions.

Option 3 – External proxies

4.31 Under this option, we would seek to use external decisions on effectiveness of treatments as the basis for what is included within the scope of the programme. Examples of how we could achieve this are:

- Aligning with NHS and social care commissioning frameworks
- Reference to external expertise such as NICE and its equivalents for Northern Ireland, Scotland and Wales.

4.32 This approach would need to recognise that advice on individual occupations and treatments can vary significantly across the UK. There are differences in which treatments are available to patients depending on country, and region within England. For example, many treatments not widely available through the NHS, such as homeopathy, are legal.

Question 5: Do you think the Authority should take account of evidence of effectiveness of occupations in its accreditation decisions, and if so, what is the best way to achieve this?

Funding model

4.33 Currently, the Authority charges a flat fee of approximately £13,800 for applications for accreditation. It charges a flat fee of approximately £10,500 plus 10p per registrant for annual renewals. This means that all Accredited Registers, regardless of size and ranging from the current registrant bases of 100 to 34,000 pay within a small range of each other. The fees we charge go towards our operating costs, but do not cover them.

4.34 We are seeing an increasing tendency for registers to merge or to join an existing register. We believe that it is a positive development but under the current fee model it reduces our income. The current funding model also does not allow for the range in the size of Accredited Registers in terms of membership, or complexity in terms of the number of occupations registered.

4.35 To future-proof the financial viability of the programme, we propose to change our funding model to a per-registrant fee, in line with the fees paid to us by statutory regulators. Assuming the current number of total practitioners, and maintaining our operating costs as now, the cost per registrant would be approximately £6 per year.

Question 6: Do you think that changing the funding model to a 'per-registrant' fee is reasonable? Are there any other models you would like us to consider?

Proposals for the future

4.36 Our vision for the future is for a simpler system for patients, the public and employers to navigate. Oversight should be proportionate to the risk of occupations.

4.37 Our proposals for the future are aimed at achieving:

- The ability to provide oversight for the new and expanding unregulated roles which have been identified as workforce priorities.
- Greater consistency of control of entry to registers within an occupation including consistent education and training standards.
- The ability to exclude unsuitable practitioners from high risk occupations
- A summary of the main changes proposed for the future are outlined below.

Stratification of occupations according to risk

4.38 There is significant variation in the risk to the public from the different occupations included within the current scope of the programme. A 'one size fits all' approach means that the same assurances are in place for more invasive occupations.

4.39 We propose to develop criteria for different 'tiers' of occupations within non-statutory regulation, according to risk to patients and the public, as the first step towards a more coherent system. This could include criteria for identifying when an occupation should undergo an in-depth assessment of whether it poses high enough risk to warrant a recommendation to the Government for consideration of statutory regulation.

4.40 Introducing greater stratification of risk in this way would allow us to identify which occupations should be prioritised for greater assurance mechanisms, such as licensing and consistency of standards for education and training.

Consistency of standards for education and training

4.41 The original design principles for the programme included that it 'should not set the education and training requirements for entry onto a register.' However, education and training are often the key mechanisms used by registering bodies for determining eligibility of potential registrants. Differing approaches across these bodies means that there is no common threshold for competence, even within the same occupation. It also means the skills and knowledge of practitioners within the same occupation can vary significantly depending on which body they are registered with. This can lead to a lack of clarity for patients and service users.

4.42 The development of common standards within the NHS for some non-statutory roles, and between some of the current Accredited Registers, shows that consistency in education and training is valued. It provides clarity and certainty for employers and allows practitioners to transition between jobs and locations. There is also a risk that requiring a common standard may stifle innovation and reduce patient choice. This could be mitigated by having clear entry points to the occupation aligned to a career pathway.

4.43 We can see benefits of greater consistency and that the Authority could play a greater role in helping to shape standards. Whilst the Authority will not be best placed to set the specific standards for an occupation, we would want to work with Accredited Registers and other stakeholders towards this goal. We would start with occupations where common education and training standards are already a stated goal, either by the profession itself or as part of NHS workforce strategies. Working with others, we would seek to support the development of and ultimately endorse common frameworks, adopting them into our Standards for Accredited Registers.

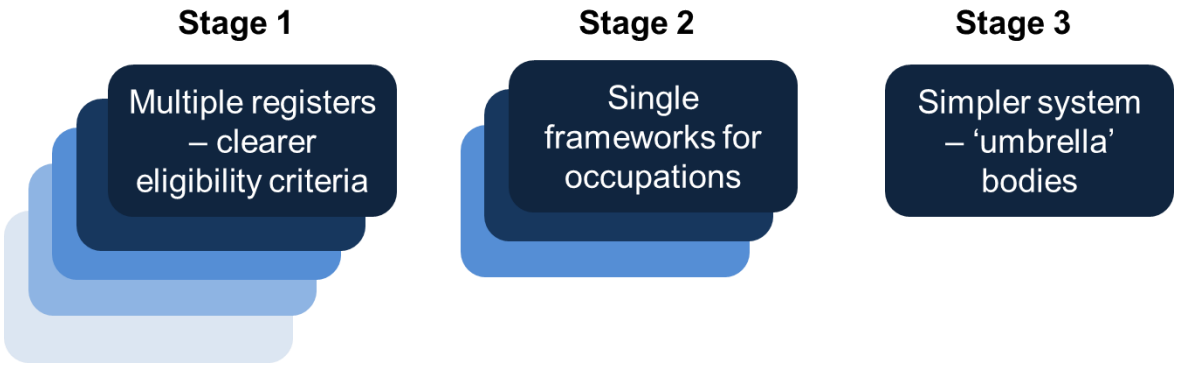
4.44 This would be a step-change for registering bodies and their practitioners but is one we think is needed to promote the interests of patients and service users by creating a clearer system to navigate and ensuring greater consistency of the competence and safety of practitioners. It would also pave the way for the simplification of the system, with potentially fewer organisations accredited by the Authority.

Shaping simplicity within the system

4.45 Common standards for education and training for individual occupations would allow common frameworks to be introduced. This would in turn allow for registers to join as single entities, and to function as 'umbrella' registers. This would achieve greater simplicity, and clearer requirements which should give employers greater confidence and help protect patients and members of the public choosing these services.

4.46 This could ultimately lead to the creation of a single register for non-statutory roles, as envisaged in Re-thinking Regulation. However, we recognise that this would be a significant shift and may require legislative change to achieve. For this reason, we are planning a phased approach, in partnership with Government, the NHS, social care and independent sector to our proposals and in keeping with our own Right-touch principles, to only make changes that are proportionate and necessary to address the risks.

4.47 The diagram below sets out the key stages in this approach.



Question 7: Do you think that our proposals for the future vision would allow greater use and recognition of the programme by patients, the public, and employers? Are there any further changes you would like us to consider?

Safeguarding and public protection

4.48 In parallel to the changes for 2021/22 and longer term, we will continue to explore opportunities for greater access to safeguarding checks for Accredited Registers.

4.49 The previous Government's 2011 Command Paper *Enabling Excellence* stated that 'We will also ensure that any voluntary registration systems accredited by [the Authority] make appropriate links to the wider regulatory system and include appropriate policies on professional indemnity and safeguarding, including, where appropriate, procedures for making referrals to the Independent Safeguarding Authority (ISA) or Disclosure Scotland, where individuals are considered to pose a risk to the public.'

4.50 However, currently the Accredited Registers are not fully included in safeguarding legislation. For example, they are unable to access information about whether an individual has any relevant spent convictions, e.g. for violence or sexual misconduct, when making decisions about whether to allow an individual to join the register which makes it harder for them to ensure that their registrants do not pose a risk to the public.

4.51 The Authority has called for the Rehabilitation of Offenders Act 1976 and the Safeguarding Vulnerable Groups Act 2006 to be changed to enable registers accredited under the programme to be listed as 'register holders' and therefore to access the relevant information to assist when making decisions on whether to allow an individual to join the register. This legislation is owned by multiple governmental departments including the Home Office and the Ministry of Justice.

4.52 Our discussions with Government to date have indicated that to move forward, there must be clarity on the status of Accredited Register practitioners. This would require extending the legal definition of 'healthcare' to those included within the scope of the programme.

4.53 The Covid-19 pandemic has further highlighted the lack of clarity about the legal classification of Accredited Register practitioners. Covid-19 guidance and regulations across the UK did not refer specifically to Accredited Registers. The group was generally described as providing 'close contact' and 'personal care' services. At times, this created confusion about whether activities undertaken for health purposes, such as sports massage, could take place.

4.54 Lack of clarity of status of practitioners, and lack of access to safeguarding information, means that patients and the public may be put at risk. Given the importance of the mental health and other services provided by non-statutory roles, greater assurances of practitioners would also allow them to make a greater contribution to workforce shortages.

4.55 We propose that the Authority should explore, with the support of the Department for Health and Social Care, how to achieve greater clarity of the status of Accredited Register practitioners. We recognise that the variety of occupations covered by the Accredited Registers programme can present a challenge in classifying as a homogenous group for legal purposes. If this remains the key barrier, we will explore whether certain occupations that present higher risk should be designated as a separate tier. We will advocate for the legislative changes required to recognise this group.

Question 8: Do you agree that to protect the public, the Accredited Registers should be allowed to access information about relevant spent convictions?

Impact assessment of the proposals

4.56 We are keen to ensure that we understand any impact or burden that our proposals are likely to create so that we can consider any changes that may be appropriate.

4.57 Potential impacts we have identified so far include:

- Greater assurance in areas of most patient need, through greater alignment to NHS requirements. This could have a beneficial impact on disadvantaged groups. Modifications to the programme so that it has greater application within person-centred approaches could therefore have a positive impact on disadvantaged groups by contributing to greater health literacy.
- Reduced assurance of occupations or registers which do not meet revised criteria or Standard 6. This could lead to reduced standards of practice for some registers, and consequently patients and members of the public who continue to choose their services. However, this is likely to be an indirect consequence of changes to the programme since our own research shows that it is generally recommendations from friends and family, rather than accreditation, which currently drives patient choice.
- Adverse impact on registrants whose registers don't meet new criteria due to introducing clearer hierarchies of practice. This could lead to loss of income and/or employment prospects. This could disproportionately affect some groups who practice or seek treatment from these activities. We will seek to improve our understanding of the characteristics of this group during consultation and desk-based research.
- Greater exercise of control through accreditation criteria and/or the Standards could help reduce risk of harm to patients and members of the public where there is greater awareness of accreditation, through a clearer distinction of expectations from accredited, and non-accredited registers.
- Potential for fees to be passed on to registrants, however as this is envisaged to be approximately £6 per year, we think it is likely to be affordable by the vast majority. We will consider a phrased approach to the introduction.

4.58 We consider that the impact of any changes can be more accurately assessed once any revised operational processes have been developed but remain mindful of the potential impact of any changes we explore throughout this review process. We seek initial views from those affected, and particularly the Accredited Registers and patients and service users, of the likely impact of the changes to the process that we have outlined here.

4.59 In all stages of our review, we will consider whether there are significant equality implications, either positive or negative, for our stakeholders. We have not identified any significant negative equality or diversity implications from our proposals and expect there to be a positive benefit for patients, service-users and the public by the changes proposed.

4.60 We would, however, welcome any feedback to ensure we consider all relevant issues. We would welcome any comments about the impact that these proposals will have.

Question 9: Are there any aspects of these proposals that you feel could result in differential treatment of, or impact on, groups or individuals with characteristics protected by the Equality Act 2010?:

- Age
- Gender reassignment
- Ethnicity
- Disability
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Other (please specify)

4.61 If yes to any of the above, please explain why and what could be done to change this.

4.62 To help us understand who is interested in the programme and is responding to our consultation, it would be helpful to find out more about you. If you would prefer not to add your name, you could tell us, for example, your area of work or interest or the type of organisation you work for (for example ‘I work for an accredited register’ or ‘I am registered with an accredited register’):

Question 10. Your name and/or the name of your organisation.

Question 11: How would you describe your organisation (or your own role if more relevant)?

5. Summary of questions and how to respond

Summary of questions

Question 1: Do you agree that a system of voluntary registration of health and social care practitioners can be effective in protecting the public?

Question 2: How do you think the Authority should determine which occupations should be included within the scope of the programme? Is there anything further you would like us to consider in relation to assessing applications for new registers?

Question 3: Do you think that moving from an annual to a longer cycle of renewal of accreditation, proportionate to risk, will enable the Authority to take a targeted, proportionate and agile approach to assessment? Do you think our proposals for new registers in terms of minimum requirements are reasonable?

Question 4: Do you think accreditation has been interpreted as implying endorsement of the occupations it registers? Is this problematic? If so, how might this be mitigated for the future?

Question 5: Do you think the Authority should take account of evidence of effectiveness of occupations in its accreditation decisions, and if so, what is the best way to achieve this?

Question 6: Do you think that changing the funding model to a 'per-registrant' fee is reasonable? Are there any other models you would like us to consider?

Question 7: Do you think that our proposals for the future vision would achieve greater use and recognition of the programme by patients, the public, and employers? Are there any further changes you would like us to consider?

Question 8: Do you agree that to protect the public, the Accredited Registers should be allowed to access information about relevant spent convictions?

Question 9: Are there any aspects of these proposals that you feel could result in differential treatment of, or impact on, groups or individuals with characteristics protected by the Equality Act 2010?

Question 10. Your name and/or the name of your organisation.

Question 11: How would you describe your organisation (or your own role if more relevant)?

How to respond

5.1 You can respond to this consultation paper by completing the Word document available here and submitting it by email to: ARconsultation@professionalstandards.org.uk.

5.2 Due to the pandemic, we strongly urge responses by email. If this is not possible, our postal address is:

Professional Standards Authority
157-197 Buckingham Palace Road
London
SW1W 9SP

5.3 If you have any queries, or require an accessible version of this document, please contact us on 020 7389 8030 or by email at accreditationteam@professionalstandards.org.uk.

5.4 Please return your response to us by **18 February 2021**.

6. Confidentiality of information

6.1 We will manage the information you provide in response to this discussion paper in accordance with our information security policies which can be found on our website (www.professionalstandards.org.uk).

6.2 Any information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA) the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

6.3 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, 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 us why you regard the information you have provided as confidential.

6.4 If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality will be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Authority.

6.5 We will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

7. Our consultation process and feedback

7.1 Our consultation process is based on the current Cabinet Office principles on public consultation, 'Consultation principles: guidance'. When conducting public consultations on aspects of the Authority's work we aim to:

- Be clear about both the consultation process and what is being proposed. This gives respondents the opportunity to influence our thinking and consider the advantages and disadvantages of our proposals
- Consult formally at a stage where there is scope to influence the policy in order that consultations have a purpose

- Give enough information to ensure that those being consulted understand the issues and can provide informed responses. We include assessments of costs and benefits of the options considered
- Seek collective agreement before publishing a written consultation particularly when consulting on the new proposals
- Consult for a proportionate amount of time, taking a judgement based on the nature and impact of the proposals. Consulting for too long will unnecessarily delay policy development and consulting too quickly will not give enough time for consideration and will reduce the quality of responses
- Ensure our consultation is targeted to consider the full range of stakeholders, bodies and individuals affected by the policy and include relevant representative groups. Consider targeting specific groups if necessary.
- Consider consultation as an ongoing process, not just about formal documents and responses.
- Analyse responses carefully and explain the responses received and how they have informed the policy. Give clear feedback to participants following the consultation. Publish responses to the consultation within 12 weeks or explain why that it is not possible
- Allow appropriate time between closing the consultation and implementing the policy.

7.2 If you have concerns or comments which you would like to make relating specifically to the consultation process itself, please contact us:

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