



House of Commons
Health Committee

2014 Accountability hearing with the Health and Care Professionals Council

First Report of Session 2014–15

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 10 June 2014*

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership¹

[David Tredinnick MP](#) (*Conservative, Bosworth*) (Acting Chair)

[Rosie Cooper MP](#) (*Labour, West Lancashire*)

[Andrew George MP](#) (*Liberal Democrat, St Ives*)

[Barbara Keeley MP](#) (*Labour, Worsley and Eccles South*)

[Charlotte Leslie MP](#) (*Conservative, Bristol North West*)

[Grahame M. Morris MP](#) (*Labour, Easington*)

[Andrew Percy MP](#) (*Conservative, Brigg and Goole*)

[Mr Virendra Sharma MP](#) (*Labour, Ealing Southall*)

[Valerie Vaz MP](#) (*Labour, Walsall South*)

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*)

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and by The Stationary Office by Order of the House.

Evidence relating to this report is published on the Committee's website at www.parliament.uk/healthcom.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Laura Daniels (Committee Specialist), Stephen Aldhouse (Committee Specialist), Daniel Moeller (Senior Committee Assistant), Nathan Hug (Committee Assistant), and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk

¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010). The Speaker announced his resignation as Chair on 4 June 2014. On 10 June 2014 the Committee chose David Tredinnick to act as Chair of the Committee for all further meetings until a new Chair is elected by the House.

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	7
2 Current regulatory activities	8
The remit of the HCPC	8
Breadth of HCPC's role	8
Regulation of social work	9
The assessment of the Professional Standards Authority	10
The view of the professions	12
Time taken to conclude Fitness to Practise hearings	13
Revalidation or 'continuing fitness to practise'	14
The Francis report	17
3 Regulation of social care workers	22
4 Proposed regulation of other professions	30
Herbal medicine practitioners and non-medical public health specialists	30
Statutory regulation of other new groups	32
Conclusions and recommendations	37
Formal Minutes	40
Witnesses	41
Published written evidence	42
List of Reports from the Committee during the current Parliament	43

Summary

Earlier this year, the Health Committee held an accountability session with the Health and Care Professions Council (HCPC), forming part of the Committee's regular programme of accountability sessions with health and care regulators. The Health and Care Professions Council (HCPC) is an independent statutory regulator of 319,637 individuals across 16 health, psychological and social work professions. The professions are: arts therapists; biomedical scientists; clinical scientists; chiropodists / podiatrists; dietitians; hearing aid dispensers; occupational therapists; operating department practitioners; orthoptists; paramedics; physiotherapists; prosthetists / orthotists; practitioner psychologists; radiographers; social workers in England; and speech and language therapists.

The PSA have reported to us that in 2012-13 the HCPC met all its standards of good regulation. It also stated that "the HCPC has maintained its efficient and effective performance across all areas of responsibility." The PSA consider that the HCPC's performance in 2012-13 is particularly notable as it has completed the transfer of social workers during this period, increasing the volume of allegations it is handling, and expanding its scope. However, the PSA did highlight the specific issue of routine health checks for registrants who are convicted of drink or drug related offences. The HCPC has argued that rather than introducing a blanket policy of health checks, a case-by-case approach is more proportionate. We will revisit this issue next year. In addition to this, evidence from we received from organisations representing professions regulated by the HCPC also raised some specific concerns about the HCPC's fitness to practise processes. We recommend that the HCPC consider the individual points raised in written evidence by these organisations, and provide a response to those organisations, to ensure that their feedback is used, where necessary, to improve processes.

The HCPC reported to us that in 2012-13 the average total length of time to close all cases was 9 months; the average length of time to conclude cases that went through to a final hearing was 16 months. However, reporting 'average' timescales can conceal wide variations and certain cases taking an unacceptably long time to resolve—indeed the HCPC report that in 2012-13, 27 cases took in excess of 24 months to conclude. We urge the HCPC to commit itself to a clear "start to end" target setting out the maximum length of time it takes to conclude its Fitness to Practise processes, and in our view the maximum time should be 12 months. Such a target represents a commitment from the HCPC to the patients and service users it aims to protect, and to its registrants, and should be clearly communicated on its website.

The Francis report has thrown a spotlight on the role of health and care regulators in ensuring public protection, as healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they have about the safety and quality of care being delivered to patients. For the effective regulation of clinical and caring professions, regulators need to be visible and accessible to registrants, and also to patients and members of the public who wish to raise concerns about patient safety. Regulatory bodies must also collaborate effectively with between themselves. We

recommend that the HCPC continues to monitor its own profile both with patients and service users, with professionals, and with other relevant organisations, and we will seek further evidence of the progress the HCPC and other professional regulators have made in implementing the recommendations of the Francis report at our next accountability hearings in the autumn.

The issue of ensuring standards for social care workers is crucial to delivering safe, high quality care for patients, and the Committee is concerned by the most recent in a series of reports of abuse by social care workers. In 2011 the Government proposed a voluntary register, but no progress has been made since then and we agree with the HCPC that in any event voluntary registration would not be effective. We recommend that, as a first step to improve regulation in this sector, the Government should publish plans for the implementation of the HCPC's proposals for a negative register. Beyond the establishment of a negative register, we recommend that the Government, working with the PSA and the HCPC, develop further proposals for more effective regulation to provide proper safeguards in this area. The Committee had expected that the Law Commission's draft Bill would form part of the Government's plans for the final year of this Parliament, but it was not referred to in the Queen's Speech. We ask the Department of Health to set out in response to this report what changes it proposes to make to the powers of regulatory bodies by secondary legislation during this session of Parliament, and when it anticipates that they will be brought forward.

The HCPC has a record of assimilating new professional groups onto its register, and most recently the Government has suggested that herbal medicine practitioners, and non-medical public health specialists should be added. Members of 'aspirant' groups such as these may experience frustration owing to delays and uncertainty, as the HCPC has reported to us that it is unable to commit resources to developing its approach to potential new groups until the Government has introduced legislation. The UK Public Health Register has raised a number of concerns relating to the proposed regulation of non-medical public health specialists. We recommend that the HCPC engages directly with the UK Public Health Register to ensure its concerns are registered.

In addition to this, since 2003, the HCPC has recommended to Government that statutory regulation be extended to eleven other professions. Of these, the only group to receive statutory regulation to date are operating department practitioners and practitioner psychologists. Statutory regulation gives professions, in the words of the HCPC, "a huge badge of respectability, professionalism and endorsement." Decisions about whether to extend statutory regulation to different professions need to be informed both by considerations of issues of patient safety, and consideration of the evidence base for that profession. We do not seek to make judgements on either of these factors for individual professions, and, although as the HCPC has pointed out that health and care regulation is not currently "a very logical landscape", at this stage we are not seeking to make recommendations for change simply to address inconsistencies. However, if there are unregulated groups which need to be regulated on the grounds of patient safety, this should be dealt with swiftly. We recommend that, in responding to this report, the HCPC lists any professional groups for which they feel there is a compelling patient safety case for

statutory regulation so that we can take this further with the Department of Health as a matter of urgency. We are concerned at the length of time it can take for professional groups to gain statutory regulation. As we understand that new groups can be added to the HCPC's register by means of secondary legislation we see no reason why there should be undue delay in extending statutory regulation to professional groups where there is a compelling patient safety case for doing so.

1 Introduction

1. On 7 January 2014, the Health Committee held an accountability session with the Health and Care Professions Council (HCPC). It is the first such session that the Committee has held with the HCPC. This accountability session forms part of the Committee's regular programme of accountability sessions with health and care regulators. In line with practice for previous accountability hearings, the Committee did not put out a formal call for evidence or Terms of Reference for this session, but issued a press notice in November inviting interested parties to submit evidence. The Committee received eight submissions of written evidence.

2. The Health and Care Professions Council (HCPC) is an independent statutory regulator of 319,637 individuals across 16 health, psychological and social work professions.² The professions are: arts therapists; biomedical scientists; clinical scientists; chiropractors / podiatrists; dietitians; hearing aid dispensers; occupational therapists; operating department practitioners; orthoptists; paramedics; physiotherapists; prosthetists / orthotists; practitioner psychologists; radiographers; social workers in England; and speech and language therapists.³

2 Figure correct as at 1 November 2013

3 HCPC, ([HCP0001](#)), para 2.1

2 Current regulatory activities

The remit of the HCPC

3. The HCPC was established by Parliament under the Health and Social Work Professions Order 2001. Its predecessor, the Council for Professions Supplementary to Medicine (CPSM), was established in 1961. The HCPC states that:

Our main objective is to safeguard the health and wellbeing of persons using or needing the services of our registrants and we do this by:

- setting and maintaining standards for professional skills and conduct;
- maintaining a register of professionals who meet these standards;
- approving and monitoring education programmes leading to registration; and
- taking action when a registrant's fitness to practise falls below our standards.

We also protect professional titles, with all the professions having at least one protected title. It is a criminal offence for someone to claim to be registered when they are not, and we take action against those who do so.⁴

4. The Council is an independent, self-funding organisation. It is regarded as a public body but it is not part of the Department of Health or the NHS. All its operational financial costs are funded by fees from registrants. The fees are set out in the Health Professions Council (Registrations and Fees) Rules 2003 and any fee increase is subject to a consultation and must be approved by the Privy Council. From time to time, grants are received from the Department of Health in relation to specific projects.⁵

5. In its most recent annual report, the HCPC describes 2012-13 as “a year of significant growth and change”, during which, in August 2012, over 88,000 social workers transferred onto their register.⁶ Even aside from taking on social workers the HCPC register has been increasing—the HCPC report that, in the five years since 2008, net registrant numbers have risen by 20%, excluding the registrants who transferred from the GSCC.⁷

Breadth of HCPC's role

6. The HCPC has a broad remit, covering 16 different professions. The Committee asked the HCPC about the implications of this in its oral evidence session. Anna van der Gaag, the Chair of the HCPC, said:

4 HCPC ([HCPC 0001](#)), paras 2.3-2.5

5 HCPC, [Annual Report and Accounts 2012-13](#), p4

6 HCPC, [Annual Report and Accounts 2012-13](#), p3

7 HCPC, [Annual Report and Accounts 2012-13](#), p5

The key thing here is that we work very closely with a large number of partners who are drawn from the professions themselves, as well as from other disciplines. We have both lay partners and professional partners who work with us on a sessional basis and are involved in the day-to-day decision making of the regulator. They are the ones who handle things right from the registration process, so deciding who comes on to the register, through to visits to universities, so approval and quality assurance of education programmes, and all the fitness-to-practise work that we do. The system could not operate without the expertise of those individuals. Obviously, the recruitment, training and quality assurance processes for those partners are important to how we work.⁸

7. The HCPC argued that it was more than just 16 sub-regulators joined together:

From day 1, the organisation was set up where we do the things identically wherever possible; we try to not be different for different professions. In that way I think you get a very efficient regulator. When we started doing that, the reaction of the professional bodies to the idea, for example, that you could have the same sort of standards for the professions was, “How can that possibly work, if at one end of the spectrum you have clinical scientists and at the other end of the spectrum you have arts therapists?” Our view was that you can set up a regulator where you have common processes and systems, and I think we have demonstrated that it really works very efficiently.⁹

8. Marc Seale, the HCPC’s Chief Executive and Registrar, said that in his view the HCPC operated efficiently for three reasons:

The first is that if you have lots of professions and professional bodies, you tend to try to come up with a degree of consensus, so the extreme views—the very odd ways of doing things—are eliminated and you get a good, solid centre. The second is a technical thing that you avoid regulatory capture by the professions that you are regulating, because one profession does not have that huge influence on the regulator. The third component is that you get economies of scale and therefore you can deliver regulation very effectively as well.¹⁰

Regulation of social work

9. In August 2012, over 88,000 social workers transferred onto the HCPC’s register.¹¹ The PSA argue that the HCPC’s performance in 2012-13 was particularly notable given that it completed this transfer within this period.¹² Social workers in England now account for

8 Q2

9 Q3

10 Q3

11 HCPC, [Annual Report and Accounts 2012-13](#), p3

12 Professional Standards Authority, [\(HCP 0002\)](#) para 2.2

26.8% of the HCPC's register, and 44.3% of its total Fitness to Practise cases; 0.88% of registered social workers were subject to concerns.¹³

10. Anna van der Gaag described the steps that had been taken to prepare for taking on this new responsibility:

Certainly in terms of our own governance, we have been very fortunate. We have a social worker on the governing council, so clearly we get expertise at a strategic, oversight level. In terms of having the right expertise in the right place at the right time, we have an established record on engagement and communication, and on making sure that, where we need expertise, we seek it out. We make no pretence of knowing about social work practice, but we make sure that we bring in experts from the field and recruit them as our partners, as Marc has said. If we have to develop standards, we make sure that we have people from all elements and areas of the profession involved in that process.¹⁴

11. When asked about how the HCPC handles the arguably more subjective nature of judgements in social work when compared to some other clinical professions, Dr van der Gaag responded as follows:

I think that that is an important point. I do see that there will be circumstances in which there will be much clearer objective parameters around a judgment, and others where the nature of the relationship—how it is interpreted and how it is understood—will be very difficult, because there will often be diametrically opposed views on that relationship. That certainly is the case in social work practice, and we would be very aware of it. I think it would also be the case in other disciplines—perhaps not to the same extent, but certainly in psychology, occupational therapy, speech and language therapy, and arts therapy—that there would be those perhaps more subjective elements and judgments to be made.¹⁵

The assessment of the Professional Standards Authority

12. In their written submission to the Committee, the PSA report that:

In 2012/2013 the HCPC met all our standards of good regulation. This demonstrated an improvement on 2011/2012 where we found that the HPC (as it was at the time) was not meeting the third standard of good regulation for education and training.

We consider that the HCPC's performance in 2012/2013 is particularly notable as it completed the transfer of the register of social workers in England during this period. This added over 80,000 registrants to the HCPC

13 HCPC, [Fitness to Practise Annual Report 2013](#), p13

14 Q21

15 Q22

registers, making it the second largest regulator in the health and care professions sector in the UK.

Despite the considerable additional work involved in preparing for and implementing the transfer of the regulation of social workers in England, the HCPC has maintained its efficient and effective performance across all areas of responsibility. This noteworthy given the increase in the volume of allegations it is handling and the expansion of its scope.¹⁶

13. The PSA's written evidence highlights findings from an audit carried out in June 2013 of 100 cases that the HCPC closed in the initial stages of its FtP investigation process, which is part of the PSA's regular three-year cycle of risk-based auditing. The PSA provide the following summary of this year's audit of the HCPC:

In our previous audit of the initial stages of the HPC's FtP processes, published in February 2010, we found that they dealt with cases 'efficiently and effectively' and that 'the vast majority of decisions taken on cases were reasonable and protected the public'.

Our conclusion from our 2013 audit was that the general case work system operated by the HCPC demonstrates that public protection is maintained. We identified a number of examples of good practise, specifically around active case management and progression of cases.

However we found areas for improvement in 53 of the 100 cases we audited, including 25 cases where we had concerns about decision making and six cases where we considered there were potential implications for public protection and/or maintaining public confidence in the professions or the system of regulation. The HCPC has outlined actions to address the areas of concern we highlighted in report.¹⁷

14. At the Committee's evidence session with the PSA in July 2013, the PSA raised the issue of health assessments for registrants who had drink or drugs related convictions.¹⁸ Further detail is provided in the PSA Annual Performance Review Report:

The HCPC commissioned research in August 2012 into the concepts of public protection and impairment of a registrant's fitness to practise in relation to ill health. This was in response to our earlier recommendation that regulators should routinely request a health assessment for all registrants who are convicted of a drug or drink-related offence. Following the consideration of the results of the research in February 2013 the HCPC concluded that it will continue with its approach of not routinely requesting a health assessment in such cases but considering it on a case-by-case basis. We are disappointed by this as we note that other regulators have found that investigating convictions and cautions involving drugs and alcohol has led to

16 Professional Standards Authority, ([HCP 0002](#)) para 2.1-2.3

17 Professional Standards Authority, ([HCP 0002](#)), paras 3.2 – 3.4

18 Oral evidence taken on [9 July 2013](#), HC 528-1, qq7-9

identifying an underlying health and performance concern in the registrant which might otherwise not have been apparent. However we note that the HCPC's decision is based on evidence which it has assessed. We will continue to keep this issue under review.¹⁹

15. Responding to a question about this in oral evidence, the HCPC explained their position:

First, we very much agree with the PSA on the seriousness of drink and drug-related offences. The issue for us is more about how we deal with those cases. Our assertion is that each case should be looked at individually: the circumstances surrounding drink-driving, for example, can be very different for different registrants and therefore the case-by-case approach that we take is, we think, fair, proportionate and appropriate for those on our register.

Having said that, we have set out clear criteria in our guidance on where a drink or drug-related offence will be taken through to an investigation stage—for example, if it is a repeat offence; if the offence occurs during the course of the registrant carrying out professional duties; if there is any sense that there were aggravating circumstances, such as a failure to provide a specimen or failure to co-operate with the police; or if the penalty imposed exceeds the maximum mandatory disqualification. We have those four criteria that automatically lead to further investigation, but we must be absolutely clear on whether the actual incident has an impact on fitness to practise. There are instances where that is not the case, so to take a blanket approach, in our view, is not the right approach.²⁰

The view of the professions

16. The Committee received evidence from two organisations representing professions that are regulated by the HCPC—the Chartered Society of Physiotherapy, which represents 52,000 physiotherapists, physiotherapy students, and support workers, and the Association of Educational Psychologists, which represents 2,750 Educational Psychologists registered with the HCPC. The Association of Educational Psychologists outlines a number of concerns about the HCPC's Fitness to Practise process. These include feedback that “in some cases investigations are not carried out thoroughly” and “Fitness to Practise issues are dealt with inconsistently”. They also raise concerns that “within the HCPC there is only a partial understanding of the work of educational psychologists” and “apparently high staff turnover”. The information was compiled by the Association of Educational Psychologists on the basis of feedback from members.²¹

17. The Chartered Society of Physiotherapy (CSP) reports that it believes “that the HCPC is an effective regulator, which takes a proportionate approach and provides a sound

19 Professional Standards Authority, [Annual Report and Accounts and Performance Review Report 2012-13](#), p 83, para 16.36

20 Q8

21 Association of Educational Psychologists ([HCP 0008](#)), paras 3-9

regulatory framework for physiotherapy and other Allied Health Professionals. The model of being a regulator of a large number of professions is one that works well, with distinct advantages, deriving from its cross-professional approach, which are strongly in the public interest”.²² However, the CSP does highlight “certain areas for improvement” in fitness to practise arrangements, including a need to bring down waiting times, and concerns that the initial investigation process is not always sufficiently robust, leading to potential difficulties at fitness to practise hearings.²³

Time taken to conclude Fitness to Practise hearings

18. The HCPC wrote to us following the accountability hearing, providing further information about the time taken to conclude their Fitness to Practise hearings:

In 2012-13 the length of time taken for a matter to be considered by an Investigating Committee Panel from the standard of acceptance being met is a mean of six months and a median of four months. For those cases which were referred to a final hearing, the mean and median average from receipt of allegation to consideration by an Investigating Committee Panel was seven and five months respectively.

In 2012-13 the total length of time for a case to conclude from receipt of allegation to conclusion at final hearing was a mean average of 16 months and a median average of 14 months. 27 cases took in excess of 24 months from receipt of allegation. The mean and median length of time from the date of the Investigating Committee Panel to conclusion at final hearing was a mean average of nine months and a median average of eight months.

In 2012-13, the total length of time to close all cases from the point a case was received to case closure at different points (closure without consideration by an investigating committee panel, closure by an investigating committee panel, closure at final hearing) was a mean average of nine months and a median average of six months.²⁴

19. The PSA have reported to us that in 2012-13 the HCPC met all its standards of good regulation. It also stated that “the HCPC has maintained its efficient and effective performance across all areas of responsibility.” The PSA consider that the HCPC’s performance in 2012-13 is particularly notable as it has completed the transfer of social workers during this period, increasing the volume of allegations it is handling, and expanding its scope.

20. The PSA has highlighted the specific issue of routine health checks for registrants who are convicted of drink or drug related offences. The HCPC has argued that rather than introducing a blanket policy of health checks, a case-by-case approach is more proportionate. We will revisit this issue next year.

22 Chartered Society of Physiotherapy, ([HCP 0009](#)), summary, p1

23 Chartered Society of Physiotherapy, ([HCP 0009](#)), para 2.6

24 HCPC supplementary evidence ([HCP 0013](#)) pp 4.5-4.7

21. Evidence we received from organisations representing professions registered by the HCPC also raised some specific concerns about the HCPC's fitness to practise processes. We recommend that the HCPC consider the individual points raised in written evidence by these organisations, and provide a response to those organisations, to ensure that their feedback is used, where necessary, to improve processes.

22. We asked the HCPC to provide us with further information on the length of time it takes to conclude fitness to practise cases. The HCPC reported to us that in 2012-13 the average total length of time to close all cases was 9 months; the average length of time to conclude cases that went through to a final hearing was 16 months. However, reporting 'average' timescales can conceal wide variations and certain cases taking an unacceptably long time to resolve—indeed the HCPC report that in 2012-13, 27 cases took in excess of 24 months to conclude. We urge the HCPC to commit itself to a clear “start to end” target setting out the maximum length of time it takes to conclude its Fitness to Practise processes, and in our view the maximum time should be 12 months. Such a target represents a commitment from the HCPC to the patients and service users it aims to protect, and to its registrants, and should be clearly communicated on its website.

Revalidation or 'continuing fitness to practise'

23. The HCPC's written evidence outlines on-going work in the area of revalidation. It uses the term “continuing fitness to practise” instead of revalidation, to describe the steps taken by regulators (and others) to support fitness to practise beyond the point of initial registration:

Since 2003, we have required registrants to renew their registration every two years. Since 2006, registrants have had a compulsory, statutory requirement to undertake continuing professional development (CPD). Our standards for CPD are focused on outcomes—the benefits of CPD to services users and quality of care. These standards are linked to registration and are underpinned by random audits. We consider that auditing is a proportionate method of ensuring compliance. We can and do remove individuals from the Register where our standards have not been met. We also have in place requirements for those seeking to return to the Register after a period out of practise.

Analysis of fitness to practise allegations against registrants has shown that the majority of cases (72% in 2012-13) are about conduct and professionalism with relatively few cases purely about lack of competence. We have been undertaking a programme of work and research to build the evidence base further and inform decisions about how we approach the assessment of continuing fitness to practise.

This has included or includes the following.

- Research (2011) looking at perceptions of professionalism by both students and educators and about why and how professionalism and lack

of professionalism may be identified. A further study is on-going looking at methods for measuring and tracking professionalism during training and beyond.

- Research (2011) looking at the potential value of service user and colleague feedback tools to provide further external input on registrants continuing fitness to practise.
- More in-depth analysis of existing fitness to practise data (2012) to look at the characteristics of registrants reaching final hearings and whether there are relationships with variables such as age, gender, work setting and route to registration which might suggest clear patterns of risk.
- More in-depth analysis of the content, outcomes and impact of the CPD standards and audits since 2006, including, for example, the extent to which annual appraisals and service user feedback form part of registrants' existing CPD portfolios.

We anticipate that the outcomes of these pieces of work will inform whether and in what ways we might enhance our existing approach to assessing registrants continuing fitness to practise. For example, we might consider requiring registrants to seek service user feedback to inform their learning and we might want to consider whether we have sufficient information on risk such that we might consider targeting our audits towards 'higher risk' groups. We consider that it is important that any further developments in this area are evidence-based and proportionate.²⁵

24. Dr van der Gaag gave further information about the HCPC's approach to continuing fitness to practise in oral evidence:

We have had the system in place since 2006 and we ask our registrants to keep up to date; to keep a record of their continuing professional development activities; and to make sure that these activities benefit patients and service users and have an impact on the quality of what they do. Those are the clear and simple messages that we give to registrants. Those are mandatory standards that have been in place since 2006.

Since 2008, we have been auditing a proportion of those on the register to ensure compliance. If they are selected for audit, they have to submit evidence to us, which is assessed by trained assessors working in pairs. They make a judgment about whether the profile is meeting the standards that we set. To date, we have audited about 11,500 individuals, of which a very small proportion have been removed from the register because they have failed to meet the standards: 0.7% have been removed from the register and a further 4% have voluntarily deregistered—having been selected for audit, they have disengaged from the process. We have now audited all the professions except social workers, who have just recently come into regulation by HCPC, and

25 HCPC ([HCPC 0001](#)) paras 4.1 – 4.5

some of them are now in the second round of audits. In terms of compliance, the numbers are pretty consistent across the 15 professions that we regulate. The system is there to assess compliance....

...We emphasised the outcomes-focused approach, which is about how continuing professional development activity benefits service users and patients. It is about outcomes, not the amount of activity undertaken. We also strongly emphasised that reflection on practice—keeping a reflective diary and thinking about the impact of learning activities on professional practice—was a key element of the process.

We have been advocating the outcomes-focused approach, the reflective approach, for the past six to seven years. It has taken time to convince some of the professions of its value, but the feedback we get now is that they recognise that the reflective process and the outcomes-based approach add value and are a more motivating force than a points system or an hours-based approach to continuing professional development. We certainly want to do more research—for example, into the impact of work setting on CPD activity. We also want to look at differentials between the professions—at the moment we do not see any great differentials in terms of pass/fail, but we have more work that we want to do in that respect.²⁶

25. When asked whether they planned to include patient feedback within their system of continuing fitness to practise, and what challenges might be associated with doing that across 16 different professions, Dr van der Gaag told us that:

A large number of our registrants, when they submit their profiles to us, already include patient feedback as one of the elements—one of the pieces of evidence. That is something that they are already doing, and they have been doing it since the first audits began in 2008.²⁷

26. They then argued that there was no ‘one size fits all’ solution in relation to patient feedback tools:

.... If you want to receive authentic and valuable feedback from, say, somebody with a learning disability, somebody who has had a stroke, or perhaps a young person who is coming to use mental health services, you need different tools. The work that we are doing now is around looking at the different types of tools that have been developed and validated with different client groups, rather than saying to our registrants, “We want you to use one tool,” which we believe will be, in the end, a blunt instrument and will not say very much about the person’s view of the practitioner.

...These tools are much better used as developmental assessments—so “formative” tools, in the language of the report, rather than summative tools, which in a sense are a yes or a no on performance. They are much better used

26 Q10

27 Q13

when they are part of a much more comprehensive feedback on a health professional's performance. So, again, we are taking note of that research and looking for a variety of ways of involving patients and service users in giving feedback to our registrants. We don't think there is a one size fits all.²⁸

27. The HCPC told us that there is no one-size-fits all solution to securing patient input into their continuing fitness to practise processes. In our view this should constitute an important part of any revalidation system, and we urge the HCPC to continue their efforts to include such feedback on a regular and consistent basis.

The Francis report

28. As the Committee set out last year in its report *After Francis: Making a Difference*, healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they have about the safety and quality of care being delivered to patients, and the Francis Report has implications for all professional regulators:

The Francis Report demonstrated that failure of professional responsibility was a key factor which contributed to failures of care at the Mid Staffordshire NHS Trust. The Committee has also constantly emphasised the importance of an open and accountable professional culture in its own reports during this Parliament.²⁹

29. The HCPC's annual report gives the following overview of the impact of the Francis report on their organisation:

In February 2013 the report of the Public Inquiry into failings in care at the Mid-Staffordshire NHS Foundation Trust was published. We have begun to consider carefully what action we might take to implement the report's recommendations. For example, as part of our review of the standards of conduct, performance and ethics we will want to strengthen our requirements for registrants around reporting and escalating concerns about poor practice. The work of the Inquiry will be of importance to us on many levels, and we are looking at our own culture as well as at our regulatory functions to see what changes we might make to ensure that we are also putting patients and service users first in all we do.³⁰

30. In their evidence to the Committee, the PSA discuss the implications of the Francis report for the HCPC:

The Francis Inquiry has thrown a spotlight on the effectiveness of regulatory and supervisory organisations, both individually and as part of a wider safety and quality structure. One of the key lessons from this Inquiry, and the

28 Q13

29 Health Committee, Third Report of Session 2013-14, [After Francis – Making a Difference](#), HC 657, para 16-17

30 HCPC, [Annual Report and Accounts 2012-13](#), p3

Government's response, is that a regulator's effectiveness should be gauged on its contribution to the achievement of the common goal of safe, high-quality care, as well as on its fulfilment of particular and focused statutory duties.

The HCPC have perhaps a greater challenge than other professional regulators in this respect, due to the breadth of their register with 16 different professions operating across a variety of settings. The efficiency and effectiveness with which it meets own statutory responsibilities is commendable. However, in the future, regulators will also be judged by the extent to which they work with others as part of the safety and quality architecture of health and social care, for the benefit of patients, service users and the wider public. This will require a more coordinated approach and the Committee may wish to understand how the HCPC plans to cooperate and collaborate with other organisations in the future to achieve common regulatory outcomes.³¹

31. The HCPC's written evidence describes how they work jointly with other regulators:

In order to carry out our regulatory functions effectively we work with relevant organisations, sharing appropriate information relating to registration and fitness to practise. One way we do this is through memoranda of understanding and such agreements are in place with a range of organisations including the Care Quality Commission (CQC) and the regulators of social workers in Northern Ireland, Scotland and Wales.³²

32. We asked the HCPC whether Memoranda of Understanding were sufficient. Marc Seale told us:

In my view MOUs are, frankly, interesting bits of paper, but what you have to be concerned about is what is happening on an operational level within the regulators. When something comes up—for example, if we get a complaint against a medic arriving at our door—do we do something about it and is that information going across to other regulators? I think MOUs are a fig leaf in terms of what we are doing. I also think that there is a tendency—I have seen it from the Shipman inquiry and various things—to say, “Oh, we are having meetings. The chief executives are getting together and we do this once a month.” There is a lot of enthusiasm at the first and second meetings, but gradually that disappears. What you have to do, and what we as the regulator try to do, is to make those contacts with other regulators. For example, we have picked up cases from other regulators—for example in the US—that have been in contact with us because we have had an individual on our register. The person came off our register and then went off to the US and did something totally inappropriate. Someone then said, “Actually, they

31 Professional Standards Authority, ([HCP 0002](#)) paras 5.1 – 5.2

32 HCPC ([HCP 0001](#)), para 2.6

have now gone back to the UK,” so those organisations phone us up and make contact, because we know them.

To me, it is about personal contact, building up that trust, and making sure that other regulators and organisations know about your existence so that the information comes across to you. Having meetings and MOUs is not going to achieve that.³³

33. When asked what difference being a multi-professional regulator made to linking in with different organisations, Marc Seale argued that, if anything, it made it easier, because they have “a bigger presence, so people are more likely to know about us.”³⁴ Dr van der Gaag added that

We invest hugely in communication and engagement. We see that as an absolutely essential part of what we do. In terms of the professions that we regulate, we have an open-door policy. If they want to contact us about anything at all, or raise concerns with us that are perhaps at a macro level, we are there. We have regular meetings, at all levels of the organisation, with officers.

Equally, we need to be in touch with organisations that are there to represent patients and service users. One initiative that has come out of Francis is work that we are doing at the moment with the Patients Association, where it is reviewing our complaints processes. There will be huge learning from that. It has set standards on complaints, and we want to know whether we meet those standards and in what way could we improve from the association’s perspective. Obviously, our hope is that, by going through that scrutiny process—we are the first regulator to do so—there will be learning that we can share with our colleagues in the other professional regulatory bodies.³⁵

34. In November 2013, the HCPC published the results of research it has carried out with the public:

The Health and Care Professions Council (HCPC) is launching new research today which finds that a fifth of UK adults have encountered behaviour from a health or care professional that made them doubt their fitness to practise.

More than a quarter said the health or care professional in question seriously or persistently failed to meet standards whilst 16 per cent said they felt the professional failed to respect the rights of a patient to make their own choices. Thirteen per cent felt they were ‘hiding mistakes’ and a further nine per cent felt they were exploiting vulnerable patients. One in twenty said they had experienced or witnessed reckless or deliberately harmful acts.

33 Q18

34 Q19

35 Q19

Despite these figures, just three out of ten reported their concerns, with a further 73 per cent of adults who would not know where to go to report concerning behaviour.

The data, released today supports research commissioned by the HCPC earlier in the year into what the general public feel they need protection from most. Findings from this report show that Illegal drug taking and shoplifting were far more likely to concern members of the public than convictions for drink driving. Dishonesty and fraud were also key concerns for most.³⁶

35. Anna van der Gaag gave more information about this work in the Committee's oral evidence session, arguing that although general awareness of regulators may be low, once people want to make a complaint to the HCPC, they find navigating their way through the system easier:

That is in fact one piece of work in quite a long line of polling initiatives that we have commissioned or undertaken over the years to try to gauge the public's understanding of professional regulation, what it is there to do and how to access it. All those reports say the same thing, which is that there is a low level of awareness about this in general. Crucially, however, there is also a clear steer that, once people need to know where to go to make a complaint, they find it a much easier route. General awareness is low, but once someone needs to make a complaint they very quickly can either use the internet or find out through their GP, their pharmacy or a number of other mechanisms, where to come to make a complaint. It is about the general awareness versus the specific route to making a complaint or raising a concern. That was what the research was focusing on.³⁷

36. Dr van der Gaag said that there was nevertheless no room for complacency on this issue:

There is never any sense with us that we are content. Of course, it would be better if there was a more general awareness. Of course, it is important to make ourselves accessible by, for example, looking at our language, both written and what we put on the website, and making sure that there is literature published in easy-read formats and in other languages. We are doing that already but there is a lot more that we can still do to make sure that we are accessible and that people can then contact us and follow through with raising concerns. We would not be in any way complacent about that. We are aware that this lack of consciousness is a general issue for regulators.³⁸

36 [HCPC launches new research and takes steps to protect the public](#), HCPC press release, 20 November 2013

37 Q16

38 Q17

37. Marc Seale also said that powers within the HCPC's legislation provide a useful means for the HCPC to investigate complaints which have been raised with them, but which a registrant may not wish to pursue further:

We have a power in our legislation called the 22(6) that enables myself as the registrar to make the complaint. For example, if there are two biomedical scientists, and one of them has concerns about the other who is working in the same laboratory, but feels very uncomfortable about making the complaint themselves, if they contact us, give us the right information and say, "Look, I really don't want to go to the next stage," I, as the registrar, make the allegation or complaint. That is a very efficient way of dealing with this issue about, "Hang on, you are not actually going to pick those ones up." It is a simple bit of legislation, but it works very effectively.³⁹

38. The Francis report has thrown a spotlight on the role of health and care regulators in ensuring public protection, as healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they have about the safety and quality of care being delivered to patients. For the effective regulation of clinical and caring professions, regulators need to be visible and accessible to registrants, and also to patients and members of the public who wish to raise concerns about patient safety. Regulatory bodies must also collaborate effectively between themselves. We recommend that the HCPC continues to monitor its own profile both with patients and service users, with professionals, and with other relevant organisations, and we will seek further evidence of the progress the HCPC and other professional regulators have made in implementing the recommendations of the Francis report at our next accountability hearings in the autumn.

3 Regulation of social care workers

39. The adult social care workforce in England has been estimated as numbering 1.63m individuals, with the majority working within the independent sector. 888,000 were estimated as working in locations regulated by the Care Quality Commission (CQC). The number of jobs in adult social care in England is projected to grow by between 24 per cent and 82 per cent between 2010 and 2025.⁴⁰

40. In 2011, the Department of Health announced that it would explore the scope for the HCPC ‘to establish a voluntary register of [adult] social care workers [in England] by 2013’.⁴¹ However, the HCPC argues that there are “significant shortcomings” to the proposed approach; instead, it has proposed the establishment of a ‘negative registration scheme’. It outlines its position as follows:

We have carefully considered this issue and concluded that there are significant shortcomings in a voluntary register being held by a statutory regulator. These are the lack of legal compulsion for individuals to be registered and the inability of the regulator to demand information or to compel witnesses when investigating fitness to practise allegations. Crucially, it also means that if someone was removed from a voluntary register they could continue to practise.

We consider there is the potential for public confusion around the status of voluntary and statutory registers being held by the same organisation. We have also concluded that there would be considerable costs involved in establishing such a register and paying for its operating costs until it was self-financing.

Recent estimates are that the adult social care workforce in England numbers 1.63m jobs. This is a large, low paid and often transitory workforce with significant numbers of part time workers. We have concluded that ‘full statutory regulation’ for this group is unlikely to be considered to be a proportionate or cost-effective response.

We have instead proposed a ‘negative registration scheme’ and statutory regulation of CQC registered managers.

A negative registration scheme would improve public protection because it would enable the regulator to deal effectively with the small number of individuals who are unsuitable to work in adult social care in England, without placing a disproportionate burden on the remainder of the workforce.⁴²

40 HCPC policy statement, [Proposal for regulating adult social care workers in England](#), February 2013, para 3.1

41 HCPC ([HCP 0001](#)), para 3.2

42 HCPC ([HCP 0001](#)), para 3.2-3.7

41. In oral evidence, the HCPC reiterated their opposition to opening a voluntary register:

Essentially, our major issue is this: we were given powers in the last change to legislation to open voluntary registers. In fact, we were asked to open a voluntary register for the care workers, and we very firmly said no. The reason for that is that, first, there is no protection of title, so you cannot stop people using a title. Secondly, you cannot run fitness to practise, because you cannot demand witnesses to turn up and you cannot get hold of documentation. And, thirdly, if an individual drops off a voluntary register, you cannot take any action anyway. They are completely pointless in terms of what we do.

We can say that because until the HCPC was set up, we had a system in the UK where you had physiotherapists who were SR-ed [statutorily regulated]—they would be regulated—and then people who called themselves physiotherapists who were not regulated. The public got very confused and then very angry when they went and were treated by a physiotherapist who they thought was statutorily regulated but was not. We think that does not make sense—that is quite clear. None of the statutory regulators have opened voluntary registers and, when the Law Commission publishes its draft legislation, I think it will be fascinating to see what will be done with this anomaly. But those groups should be statutorily regulated.⁴³

42. The HCPC's proposed model would work as follows:

- A statutory code of conduct would be set for adult social care workers in England.
- Employers would be expected to resolve low level complaints.
- Those cases involving more serious complaints, particularly where service users were or would be placed at risk, would be reported to the regulator for investigation.
- There would be no registration requirement. However, the adjudication process would enable those unfit to practise as adult social care workers in England to be prevented from doing so by being included on a 'negative register'.
- It would be a criminal offence to engage in adult social care in England whilst the subject of negative registration.

The 'negative registration' model draws upon a similar scheme which has been successfully operated by the New South Wales Health Care Complaints Commission for a number of years and is due to be extended to other states and territories.

All providers registered by the CQC must have a registered manager for each of the ‘regulated activities’ they carry out. Some of these individuals will be from statutory regulated backgrounds, others will not. We have proposed that these managers should become statutory regulated. This will put them on the same footing as other regulated professions by having a binding code of conduct and ethics.

We consider that these proposals might be more effective than relying on purely voluntary or self-regulatory arrangements alone. They would provide an important ‘safety net’ whilst building on other sector-led initiatives focused on assuring and improving quality in this sector.

We have submitted these proposals to Government. If the Government considered that these proposals met its policy objectives, further development work would be required.⁴⁴

43. A policy statement published by the HCPC in February 2013 outlining the proposals gives a preliminary estimate that establishing a negative registration scheme would involve a one-off cost of approximately £3m, with ongoing costs of approximately £5–6m per annum.⁴⁵ In February 2013, *Community Care* reported that the HCPC had projected the potential costs of this model as follows:

The HCPC estimates that the register would cost £3m to set up and £5-6m annually to run, plus around £1m per year in adjudication costs. This is based on a 500,000-strong workforce.

It would require a government grant to cover the start up costs and, as no annual registration fee would be collected from individual social care workers, other funding arrangements would have to be considered for operating the scheme.

Options include an annual grant from government or a levy on service providers, for example through the Care Quality Commission’s licensing fee.⁴⁶

44. The HCPC policy statement gives further information about its proposals for CQC registered managers:

All providers registered by the CQC must have a registered manager for each of the ‘regulated activities’ they carry out. Although some registered managers may be statutory regulated professionals, others will not. There are 24,610 registered managers for the CQC regulated activities which are most directly related to social care.

44 HCPC ([HCP 0001](#)) paras 3.8-3.12

45 HCPC policy statement, [Proposal for regulating adult social care workers in England](#), February 2013, para 4.12

46 “[Regulator could gain powers to issue public warnings about care staff](#)”, *Community Care*, 1st February 2013.

The CQC registration requirements ensure that individuals have the qualifications and experience necessary to manage the regulated activities but they do not put in place a binding code of conduct and ethics. The recent Winterbourne View Hospital serious case review acknowledged this, referring to establishing registered managers as a profession with a regulatory body to enforce standards.

In addition to a negative register for the remainder of the workforce, we are proposing that CQC registered managers in adult social care in England should be statutory regulated. This would put them on the same footing as other regulated professions.

The potential benefits of this approach are as follows.

- The pivotal role that these particular managers play in influencing the standards, culture and behaviour of their employees would be recognised.
- This approach would build-on the existing arrangements, increasing accountability by putting in place a binding and enforceable code of conduct and ethics.
- This approach would be proportionate and targeted by registering those individuals with direct responsibility for CQC regulated activities, rather than all those with a managerial or supervisory role.⁴⁷

45. The PSA told us that it had not established a final position on either the proposal of negative registration, or of statutory regulation of managers of CQC registered providers, but in a note summarising its early thinking on this, it raised a number of issues.⁴⁸ The PSA says that, “with national vetting and barring schemes already in place, for example the Disclosure and Barring Service, it could be argued that there is already a system of negative registration in place for this particular group”.⁴⁹ They go on to ask:

The question is therefore what additional benefits would a negative register for adult social care workers offer service users, the public and employers, and what would it cost to deliver these benefits? A negative register would not stop an initial instance of harm to a service user or misconduct by a social care worker because action could only be taken after an event. The effectiveness of this model would rely upon the effectiveness of the complaints handling process that could lead to barring decision, keeping the worker and key witnesses engaged in the scheme’s actions to secure a barring decision. This could be a lengthy process. We consider that there would be a number of issues and challenges that an initiative of this nature would need to address if it was to be successful in protecting the public and maintaining standards, for example:

47 HCPC policy statement, [Proposal for regulating adult social care workers in England](#), February 2013, para 5.1-5.4

48 Professional Standards Authority supplementary evidence ([HCP0011](#)), para 1

49 Professional Standards Authority supplementary evidence ([HCP0011](#)), para 2

- How would negative registration prevent barred adult social care workers from working in other related occupations?
- How would employers in adult social care be encouraged to make referrals and support the body holding the negative register through investigations and hearings?
- How would service users and the public (including carers) be supported and encouraged to make complaints and act as witnesses through investigations and hearings?
- How would service users working with personal budgets be prevented from using the services of a barred adult social care worker? Would it always be appropriate to do so?
- How would healthcare employers be prevented from employing a barred adult social care worker? Would it always be appropriate to do so?
- How would the negative register work with other approaches to registration and regulation of this group in other parts of the UK, and with vetting and barring schemes across the UK? Would it be clear under what circumstances an individual would be barred by the negative register and also by a vetting and barring scheme?⁵⁰

46. The PSA also point out that the costs associated with establishing and running a negative register would need to be ascertained:

A large proportion of the costs associated with statutory health and care professional regulation are in fitness to practise. We would anticipate that these would be similar for a negative register as all complaints would need to be received, screened, investigated, heard and, if necessary appealed, within a framework that was lawful and compliant with human rights. The costs of running the negative register would not necessarily be borne by the occupational group as is the case with assured voluntary registers and statutory professional regulation. If this is the case, it is not clear who will pay for the barring scheme.⁵¹

47. The Committee asked the HCPC what value their proposed system would add:

In terms of what this contributes that the current system does not, clearly the delivery of safe and effective care is critical in this sector, and the many agencies involved are as concerned as we are about the issue of safety and effectiveness. In fact, the Cavendish review makes very strong and powerful recommendations about training, supervision and local mechanisms to ensure that care workers are delivering safe and appropriate care.

50 Professional Standards Authority supplementary evidence ([HCP0011](#)), para 2

51 Professional Standards Authority supplementary evidence ([HCP0011](#)), para 2.4

As a regulator, we have obviously had many conversations with employers and those in the sector about this issue, and we are aware that there are a number of what you might call serial offenders—people who move from one care setting to another. If there has been an incident, they are either disciplined or asked to leave, and then they move on and find employment five miles down the road—or, more often, 50 miles down the road. What we would see as unacceptable behaviours then recur in another setting. There is currently no mechanism for holding those individuals to account.

The sector very much supports a statutory code of conduct. Skills for Care has carefully developed a code of conduct for care workers, but there are no legal powers to enforce it. We are proposing a statutory code that would allow us to investigate serious complaints about individuals who are not delivering appropriate care.⁵²

48. The Committee also asked the HCPC how their proposals would fit in with the Disclosure and Barring Service. Dr van der Gaag said that

...we would see it as very much complementing but playing a different role from the DBS, because that scheme has a higher threshold. We know that because we regularly make referrals for our own cases to the DBS, and to date in only 36% of them has the system then acknowledged that the individual should be barred. For example, in cases where there has been physical or sexual assault, or sexually inappropriate behaviour towards vulnerable individuals, those individuals have not been barred by the scheme. There is a different threshold.⁵³

49. The HCPC argued however that the need for other local mechanisms would remain:

Our contention is that there needs to be a safety net—a way of holding individuals to account against a statutory code. However, that does not in any way diminish the importance of other local mechanisms—local training, local support, local supervision and good employment practices—for what I would call the low-level complaints and the capability issues that are currently dealt with by employers.⁵⁴

50. They went on to give further detail of their discussions about this issue with stakeholders:

Our understanding from discussions with stakeholders is that they are concerned that there is no protection at the current moment in time. They cannot do anything, and they are very frustrated. But if there is a system in which they know that that standards they can trust from an independent regulator will apply, they will take account of it, because they can

52 Q24

53 Q24

54 Q24

differentiate themselves from other organisations that do not put those services in place.⁵⁵

51. They also told us that in their view, providers “would certainly say that there is no business incentive to encourage membership of a voluntary registration scheme, but there is a business incentive for them, because of the reputational reassurance it would give, as you say, and the fact that there is a statutory mechanism that they can rely on.”⁵⁶ In reference to costs, Marc Seale conceded that “the big problem with our scheme is that there is no register, and therefore you cannot charge individuals. Therefore, it may have to be funded by the Government, which is obviously a big negative thing... If the Government does not pay for it, the alternative in a licensing scheme is, for example, if you are licensing care homes, to charge a levy on the care homes to pay for the negative licensing.”⁵⁷

52. When asked if should there be a graduated series of standards within the negative register, the HCPC responded that in their view that would “be very much worth considering”. They also reported that that the Welsh administration is currently consulting on proposals for a negative register, and that Scotland are now introducing one.⁵⁸

53. The issue of ensuring standards for social care workers is crucial to delivering safe, high quality care for patients. The HCPC have told us they are opposed to running a voluntary register for social care workers, and have argued instead for the establishment of a ‘negative register’ for social care workers. In their view, although this would have cost implications, it would offer far greater public protection than a voluntary register, and they argue that it would supplement rather than duplicate the existing Disclosure and Barring Service, which in the HCPC’s view has too high a threshold.

54. The Committee is concerned by the most recent in a series of reports of abuse by social care workers. In 2011 the Government proposed a voluntary register, but no progress has been made since then and we agree with the HCPC that in any event voluntary registration would not be effective. We recommend that, as a first step to improve regulation in this sector, the Government should publish plans for the implementation of the HCPC's proposals for a negative register. The legislation that would be required to enable the establishment of such a negative register is contained in the Law Commission’s draft Bill on the regulation of health and social care professions⁵⁹. Beyond the establishment of a negative register, we recommend that the Government, working with the PSA and the HCPC, develop further proposals for more effective regulation to provide proper safeguards in this area.

55 Q25

56 Q28

57 Q27

58 Q25

59 Law Commission, [Regulation of Health Care Professionals Regulation of Social Care Professionals in England](#), Law Com No 345, April 2014

55. The Committee had expected that the Law Commission's draft Bill would form part of the Government's plans for the final year of this Parliament, but it was not referred to in the Queen's Speech. During the Queen's Speech debate, the Minister of State at the Department of Health said that the Government would do what it could through secondary legislation to implement some of the changes sought by professional regulatory bodies.⁶⁰ **We ask the Department of Health to set out in response to this report what changes it proposes to make to the powers of regulatory bodies by secondary legislation during this session of Parliament, and when it anticipates that they will be brought forward.**

60 HC Deb, 9 June 2014, col 350.

4 Proposed regulation of other professions

Herbal medicine practitioners and non-medical public health specialists

56. The HCPC has been asked by Government to add professions to its register at various points since its establishment, most recently social workers in 2012. The Government has also proposed that the HCPC should in future become responsible for regulating herbal medicine practitioners and non-medical public health specialists.⁶¹

57. The HCPC provided the following update of recent developments on plans to regulate herbal medicine practitioners.

The late Professor Michael Pitilo published his Report to Ministers from the Department of Health Steering Group on the Statutory Regulation of Practitioners of Acupuncture, Herbal Medicine, Traditional Chinese Medicine and Other Traditional Medicine Systems Practiced in the UK in 2008. It concluded: “We are firmly of the view that, in the interest of public safety, statutory regulation should now proceed with all possible speed” (p.10). The Government published a public consultation in 2009. On February 16 2011, the Secretary of State for Health, announced that the Government would introduce statutory regulation, and that this would be in place by April 2012.

On 9 July 2013, in a Westminster Hall debate on herbal medicine, the Parliamentary Under Secretary of State for Health announced the intention to set up a working group. The first meeting of the Herbal Practitioners and Medicines Working Group is scheduled to meet in early 2014.⁶²

58. With regard to non-medical public health specialists, the HCPC report that they are working with the Department of Health, but awaiting legislation in this area:

59. We have been working with the Department of Health on their project to deliver this policy. Our understanding is that the Department of Health currently intends to legislate in this parliament to regulate this group (as part of wider reforms arising from the Law Commissions' review of the regulators' legislation), with a register opening in autumn/winter 2015. However, these timescales are out of our control and may change.⁶³

60. The Committee received written evidence from the UK Public Health Register, which currently runs a voluntary register for public health professionals who do not have a

61 HCPC ([HCP 0001](#)), para 3.13

62 HCPC supplementary evidence ([HCP 0012](#)), p3

63 HCPC supplementary evidence ([HCP 0012](#)), p3

background in medicine or dentistry. This group includes some nurses, pharmacists, environmental health officers and others who are not regulated elsewhere. The UK Public Health Register states:

The lack of engagement of the HCPC with existing regulators has raised concerns over the capacity of the HCPC to deliver a comparable regulatory system to ensure consistence of regulation across the entire public health profession including Medical and Dental Public Health Consultants.⁶⁴

61. The UK Public Health Register raise some specific concerns about the regulation of public health specialists:

The public health specialists may be differentiated from most of the other professionals regulated by HCPC because the focus for public health is on population-based interventions. The knowledge, skills, competences and professional liabilities associated with population-based occupations are very different and, UKPHR would argue, require specialised competence on the part of the regulator. Public health specialists who face the prospect of regulation by HCPC might reasonably ask:

- Will HCPC expect these leaders in public health to fit in with HCPC's existing approach to regulation which inevitably, given the large number of registrants, involves more of a "tick box" process?
- How will HCPC take account of the role of public health specialists, carrying responsibility at a strategic level for protecting and enhancing the public's health, in differentiating an existing approach based largely on the regulation of practitioners who work individually with clients?
- When will HCPC commence consultation with UKPHR in particular and the wider public health community as a whole to address the many complex issues that will arise on a change of regulator?⁶⁵

62. Marc Seale told the Committee that 'aspirant' groups may become frustrated with a perceived lack of action from the HCPC, but that the HCPC cannot invest resources into preparing for new groups to join their register until the Government publishes draft legislation:

[It] is at certain times slightly frustrating for the aspirant groups, because until we see the draft legislation it is not appropriate for us to put significant resources into that project. So we will participate. We will give our advice but we won't start, for example, changing our IT systems. As soon as the Government makes the decision and publishes the draft legislation, we hit the go button. I know there are groups out there who are frustrated because

64 UK Public Health Register, ([HCP 007](#)), p1

65 UK Public Health Register, ([HCP 007](#)), para 10

they see us as not doing anything, but until we get the go-ahead from the Government we really cannot put large amounts of resources into that.⁶⁶

There is something called a section 60, which says which is the voluntary register that is going to come across. It requires us to set a standard of proficiency for the profession. It also requires us to set the standards of education and training. We set up a working group, because we do not have that knowledge. Off we go, and usually within a year or 18 months, we are ready to open a register. However, we cannot do that until the Government publish their legislation. The history of new groups is that there is a commitment to regulate new groups, then nothing happens. If we had started doing that, we would have wasted a huge amount of resources; we can't do it.⁶⁷

Statutory regulation of other new groups

63. The Health and Social Work Professions Order 2001 states that the HCPC may make recommendations to the Secretary of State and the Scottish Ministers concerning any profession which in its opinion should be regulated. Since 2003, the HCPC has recommended that 11 different professions should be regulated.⁶⁸ Of these, only operating department practitioners (2004) and practitioner psychologists (2009) have become regulated by the HCPC.

64. On 16 February 2011, the Government published a command paper, *Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*, which set out the coalition government's policy on professional regulation:

Rather than a single statutory approach regardless of local needs and local approaches, quality assured voluntary registration will provide greater flexibility and give the public and local employers greater control and responsibility for how they assure themselves about the quality of staff. For the overwhelming majority of occupational and professional groups which are not currently subject to statutory regulation and which are generally not considered to present a high level of risk to the public, but where recommendations that regulation should be introduced have been made (including those groups recommended by the HPC for statutory regulation in the past, but not yet registered), the assumption will be that assured voluntary registration would be the preferred option.

The extension of statutory regulation to currently unregulated professional or occupational groups, such as some groups in the healthcare science workforce, will only be considered where there is a compelling case on the

66 Q37

67 Q47

68 HCPC website, new professions process page
<http://www.hcpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/>

basis of a public safety risk and where assured voluntary registers are not considered sufficient to manage this risk.

The exception to this is practitioners of herbal medicine, including Chinese herbal medicine.⁶⁹

65. The Committee has received written evidence from the Registration Council for Clinical Physiologists, arguing strongly that Clinical Physiologists should be subject to statutory regulation:

Clinical physiologists work directly with patients, performing sensitive procedures such as assessments and adjustments of pacemakers, lung function tests, and both assessing and diagnosing and treating hearing loss. These can be invasive procedures, including internal ultrasound and endoscopies. Doctors and surgeons then act on the basis of the diagnosis by clinical physiologist, which can include surgeries such as neurosurgery in the treatment of epilepsy. All of these procedures pose serious risks to patients if not carried out with the highest professional standards.

Despite the sensitive and risky nature of the procedures they undertake, clinical physiologists are not subject to statutory regulation in the same way as doctors or nurses—or even professionals such as art therapists. Indeed, even though professionals responsible for dispensing hearing aids on the high street are statutorily regulated, clinical physiologists working in NHS audiology services, prescribing and fitting devices to both patients of all ages, are not.

Many of the procedures performed by clinical physiologists in the UK are performed by statutorily regulated professionals in much of Western Europe, such as doctors, and by clinicians in the United States. As a result of a specifically trained workforce, treatment and diagnosis can be provided more cost effectively by clinical physiologists in the UK, while at the same time freeing up doctors to deal with other patients. This is already happening in some areas but further developments could only take place if concerns around patient safety can be addressed through a robust system of regulation.

Clinical physiology is an increasingly specialised and advanced profession with a large number of dedicated professionals working primarily in an NHS hospital setting. In the UK, there are more than 5,000 clinical physiologists, they form part of the wider Healthcare Science workforce that includes other statutory professions such as Biomedical Scientists. Together, they carry out around 80% of diagnostic procedures in healthcare.⁷⁰

66. They argue that the “large number of unregulated or voluntary regulated healthcare professions in the NHS ... risks undermining public confidence in regulators”, as “patients

69 HCPC supplementary evidence ([HCP 0012](#)), p2

70 Registration Council for Clinical Physiologists ([HCP0005](#)), para 3.2 – 3.5

generally assume that the professionals they see in a hospital setting as an integral part of the patient care pathway are regulated like doctors and nurses are.”⁷¹

67. In the RCCP’s view, Accredited Voluntary Registration is not an appropriate alternative to statutory regulation:

From RCCP’s experience, it is not an alternative that is fit for patient safeguarding. As a voluntary register, the powers of the RCCP are severely curbed—from being unable to compel employers who contact RCCP with concerns about a registrant to give evidence to the point where the register’s administrators have themselves faced civil legal action for ‘defaming’ incompetent practitioners that they have attempted to bring sanctions against.

In practice this means that while RCCP operates a disciplinary code and procedure, it cannot protect patients from continuing to be treated by practitioners who have not been registered and who are potentially unfit to practise, as it currently has no powers of enforcement. Since 2001 the RCCP have received ten complaints that have moved to the investigatory hearing stage. In all ten cases the respondents have failed to respond and subsequently have failed to renew their membership thus removing themselves from the process. These practitioners then have the opportunity to start again in a new NHS trust or private facility, helped by a lack of awareness among NHS organisations of the voluntarily registers and the legal grey area of making membership of a voluntary registry a mandatory requirement for employment.⁷²

68. We discussed the issue of statutory regulation for further professional groups in our oral evidence session. Regarding clinical physiologists, the HCPC was clear in its support for their statutory regulation.⁷³

69. Discussing the issues relating to introducing statutory regulation more broadly, Dr van der Gaag observed that health and care regulation is currently “not a very logical landscape”, and went on to say that “if you had a clean piece of paper and redesigned the system, you would do it very differently”. However, she acknowledged the need for a pragmatic approach: “you have what you have and, in a sense, we have to move forward.”⁷⁴

70. Marc Seale argued that “regulation is a huge badge of respectability, professionalism and endorsement.”⁷⁵ The Committee asked the HCPC where, in their view, the line should be drawn on extending statutory regulation to other professions. The HCPC reported that over a number of years they had received inquiries from 53 different professions asking to

71 Registration Council for Clinical Physiologists ([HCP0005](#)), para 2.3

72 Registration Council for Clinical Physiologists ([HCP0005](#)), para 2.4 – 2.6

73 Q49

74 Q36

75 Q56

be brought into statutory regulation.⁷⁶ They stated, however, that in their view, beyond the groups they have recommended should be subject to statutory regulation, “there are not another 30 or 40 groups out there ready to be brought into the system.”⁷⁷

71. Considering the wider issue of on what basis decisions about which professions should have statutory regulation should be made, Anna van der Gaag made the following observations:

Clearly, this debate has been going on for some time. Where do you stop? It is a very good question. In a sense, as health care evolves, regulation has to respond and make decisions based primarily on public safety and protection, and it must be driven by that. There are strong and opposing views about the nature of evidence, the credibility of evidence and the evidence base of different types of professional practice ... there are certainly lots of highly contested views about the nature of evidence. We are aware of that, and to some extent that is an important driver, but it is not the primary driver for us on decisions about regulation, because the primary driver is public safety. All professions have gaps in their evidence base. I think that doctors would see that there are gaps in their evidence base, and the allied health professions would certainly say the same.⁷⁸

72. The HCPC has a record of assimilating new professional groups onto its register, and most recently the Government has suggested that herbal medicine practitioners and non-medical public health specialists should be added. Members of ‘aspirant’ groups such as these may experience frustration owing to delays and uncertainty, as the HCPC has reported to us that it is unable to commit resources to developing its approach to potential new groups until the Government has introduced legislation. The UK Public Health Register has raised a number of concerns relating to the proposed regulation of non-medical public health specialists. We recommend that the HCPC engages directly with the UK Public Health Register to ensure its concerns are registered.

73. In addition to this, since 2003, the HCPC has recommended to Government that statutory regulation be extended to eleven other professions. Of these, the only group to receive statutory regulation to date are operating department practitioners and practitioner psychologists. Statutory regulation gives professions, in the words of the HCPC, “a huge badge of respectability, professionalism and endorsement.” Decisions about whether to extend statutory regulation to different professions need to be informed both by considerations of issues of patient safety, and consideration of the evidence base for that profession. We do not seek to make judgements on either of these factors for individual professions, and, although as the HCPC has pointed out that health and care regulation is not currently “a very logical landscape”, at this stage we are not seeking to make recommendations for change simply to address

76 Q51

77 Q50

78 Q50

inconsistencies. However, if there are unregulated groups which need to be regulated on the grounds of patient safety, this should be dealt with swiftly.

74. We received written evidence from the Registration Council of Clinical Physiologists arguing strongly that Clinical Physiologists should be subject to statutory regulation, a position that the HCPC agreed with. We recommend that, in responding to this report, the HCPC lists any professional groups for which they feel there is a compelling patient safety case for statutory regulation so that we can take this further with the Department of Health as a matter of urgency. We are concerned at the length of time it can take for professional groups to gain statutory regulation. As we understand that new groups can be added to the HCPC's register by means of secondary legislation we see no reason why there should be undue delay in extending statutory regulation to professional groups where there is a compelling patient safety case for doing so.

Conclusions and recommendations

Time taken to conclude Fitness to Practise hearings

1. The PSA have reported to us that in 2012-13 the HCPC met all its standards of good regulation. It also stated that “the HCPC has maintained its efficient and effective performance across all areas of responsibility.” The PSA consider that the HCPC’s performance in 2012-13 is particularly notable as it has completed the transfer of social workers during this period, increasing the volume of allegations it is handling, and expanding its scope. (Paragraph 19)
2. The PSA has highlighted the specific issue of routine health checks for registrants who are convicted of drink or drug related offences. The HCPC has argued that rather than introducing a blanket policy of health checks, a case-by-case approach is more proportionate. We will revisit this issue next year. (Paragraph 20)
3. Evidence we received from organisations representing professions registered by the HCPC also raised some specific concerns about the HCPC’s fitness to practise processes. We recommend that the HCPC consider the individual points raised in written evidence by these organisations, and provide a response to those organisations, to ensure that their feedback is used, where necessary, to improve processes. (Paragraph 21)
4. We asked the HCPC to provide us with further information on the length of time it takes to conclude fitness to practise cases. The HCPC reported to us that in 2012-13 the average total length of time to close all cases was 9 months; the average length of time to conclude cases that went through to a final hearing was 16 months. However, reporting ‘average’ timescales can conceal wide variations and certain cases taking an unacceptably long time to resolve—indeed the HCPC report that in 2012-13, 27 cases took in excess of 24 months to conclude. We urge the HCPC to commit itself to a clear “start to end” target setting out the maximum length of time it takes to conclude its Fitness to Practise processes, and in our view the maximum time should be 12 months. Such a target represents a commitment from the HCPC to the patients and service users it aims to protect, and to its registrants, and should be clearly communicated on its website. (Paragraph 22)

Revalidation or ‘continuing fitness to practise’

5. The HCPC told us that there is no one-size-fits all solution to securing patient input into their continuing fitness to practise processes. In our view this should constitute an important part of any revalidation system, and we urge the HCPC to continue their efforts to include such feedback on a regular and consistent basis. (Paragraph 27)

The Francis report

6. The Francis report has thrown a spotlight on the role of health and care regulators in ensuring public protection, as healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they have

about the safety and quality of care being delivered to patients. For the effective regulation of clinical and caring professions, regulators need to be visible and accessible to registrants, and also to patients and members of the public who wish to raise concerns about patient safety. Regulatory bodies must also collaborate effectively with between themselves. We recommend that the HCPC continues to monitor its own profile both with patients and service users, with professionals, and with other relevant organisations, and we will seek further evidence of the progress the HCPC and other professional regulators have made in implementing the recommendations of the Francis report at our next accountability hearings in the autumn. (Paragraph 38)

Regulation of social care workers

7. The issue of ensuring standards for social care workers is crucial to delivering safe, high quality care for patients. The HCPC have told us they are opposed to running a voluntary register for social care workers, and have argued instead for the establishment of a ‘negative register’ for social care workers. In their view, although this would have cost implications, it would offer far greater public protection than a voluntary register, and they argue that it would supplement rather than duplicate the existing Disclosure and Barring Service, which in the HCPC’s view has too high a threshold. (Paragraph 53)
8. The Committee is concerned by the most recent in a series of reports of abuse by social care workers. In 2011 the Government proposed a voluntary register, but no progress has been made since then and we agree with the HCPC that in any event voluntary registration would not be effective. We recommend that, as a first step to improve regulation in this sector, the Government should publish plans for the implementation of the HCPC’s proposals for a negative register. The legislation that would be required to enable the establishment of such a negative register is contained in the Law Commission’s draft Bill on the regulation of health and social care professions. Beyond the establishment of a negative register, we recommend that the Government, working with the PSA and the HCPC, develop further proposals for more effective regulation to provide proper safeguards in this area. (Paragraph 54)
9. We ask the Department of Health to set out in response to this report what changes it proposes to make to the powers of regulatory bodies by secondary legislation during this session of Parliament, and when it anticipates that they will be brought forward. (Paragraph 55)

Statutory regulation of other new groups

10. The HCPC has a record of assimilating new professional groups onto its register, and most recently the Government has suggested that herbal medicine practitioners, and non-medical public health specialists should be added. Members of ‘aspirant’ groups such as these may experience frustration owing to delays and uncertainty, as the HCPC has reported to us that it is unable to commit resources to developing its approach to potential new groups until the Government has introduced legislation. The UK Public Health Register has raised a number of concerns relating to the proposed regulation of non-medical public health specialists. We recommend that

the HCPC engages directly with the UK Public Health Register to ensure its concerns are registered. (Paragraph 72)

11. In addition to this, since 2003, the HCPC has recommended to Government that statutory regulation be extended to eleven other professions. Of these, the only group to receive statutory regulation to date are operating department practitioners and practitioner psychologists. Statutory regulation gives professions, in the words of the HCPC, “a huge badge of respectability, professionalism and endorsement.” Decisions about whether to extend statutory regulation to different professions need to be informed both by considerations of issues of patient safety, and consideration of the evidence base for that profession. We do not seek to make judgements on either of these factors for individual professions, and, although as the HCPC has pointed out that health and care regulation is not currently “a very logical landscape”, at this stage we are not seeking to make recommendations for change simply to address inconsistencies. However, if there are unregulated groups which need to be regulated on the grounds of patient safety, this should be dealt with swiftly. (Paragraph 73)
12. We received written evidence from the Registration Council of Clinical Physiologists arguing strongly that Clinical Physiologists should be subject to statutory regulation, a position that the HCPC agreed with. We recommend that, in responding to this report, the HCPC lists any professional groups for which they feel there is a compelling patient safety case for statutory regulation so that we can take this further with the Department of Health as a matter of urgency. We are concerned at the length of time it can take for professional groups to gain statutory regulation. As we understand that new groups can be added to the HCPC’s register by means of secondary legislation we see no reason why there should be undue delay in extending statutory regulation to professional groups where there is a compelling patient safety case for doing so. (Paragraph 74)

Formal Minutes

Tuesday 10 June 2014

Members present:

Grahame M. Morris
Andrew Percy
David Tredinnick

Valerie Vaz
Dr Sarah Wollaston

Mr Stephen Dorrell having resigned as Chair, Mr David Tredinnick was called to the chair for the meeting, and for all further meetings until a new Chair is elected by the House.

Draft Report (*2014 Accountability hearing with the Health and Care Professions Council*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 74 read and agreed to.

Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till tomorrow at 4pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/health-and-care-professions-council/>.

Tuesday 7 January 2014

Question number

Dr Anna van der Gaag, Chair, and Marc Seale, Chief Executive and Registrar, Health and Care Professionals Council

[Q1-63](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/health-and-care-professions-council/> INQ numbers are generated by the evidence processing system and so may not be complete.

- 1 Angela Woosey ([HCP0006](#))
- 2 Bruce Newsome ([HCP0003](#))
- 3 Chartered Society Of Physiotherapy ([HCP0009](#))
- 4 Health and Care Professions Council ([HCP0001](#))
- 5 Health And Care Professions Council ([HCP0012](#))
- 6 Health And Care Professions Council ([HCP0013](#))
- 7 Professional Standards Authority ([HCP0002](#))
- 8 Professional Standards Authority ([HCP0010](#))
- 9 Professional Standards Authority ([HCP0011](#))
- 10 Registration Council For Clinical Physiologists ([HCP0005](#))
- 11 The Association of Educational Psychologists (AEP) ([HCP0008](#))
- 12 UK Public Health Register ([HCP0007](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/healthcom.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699 (HC 1200)
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761 (HC 1218)
Seventh Report	Public expenditure on health and social care	HC 793
Eighth Report	Public Health England	HC 840
Ninth Report	2013 accountability hearing with Monitor	HC 841
Tenth Report	2013 accountability hearing with the General Medical Council	HC 897

Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality	HC 592

	Commission	
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)
Session 2010–12		
First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)