HOUSE OF COMMONS

Health Committee

Oral evidence: Health and Care Professions Council, HC 922

Tuesday 7 January 2014

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Written evidence from witnesses:

- Health and Care Professions Council
- Health and Care Professions Council

Watch the meeting

Members present: Stephen Dorrell (Chair); Andrew George; Barbara Keeley; Charlotte Leslie; Mr Virendra Sharma; David Tredinnick; Valerie Vaz

Questions 1-63

Witnesses: **Dr Anna van der Gaag**, Chair, and **Marc Seale**, Chief Executive and Registrar, Health and Care Professions Council, gave evidence.

Q1 Chair: Good afternoon, and thank you for joining us this afternoon. I should say at the outset that there is business on the Floor of the House this afternoon and we have been warned by modern methods that we are likely to be disturbed by a vote at any moment. Apologies; when the bells go, we shall leave you for a few minutes, but we shall be back.

You are very welcome to this session. It is the first time, I think—certainly in this Parliament—that the Committee has met the HCPC. We do so having established through this Parliament regular sessions with the GMC and the NMC, and in the belief that we should be looking more widely at questions of clinical professional regulation in health and social care. You are welcome against that background. I ask you to introduce yourselves briefly.

Dr van der Gaag Good afternoon. My name is Anna van der Gaag. I am the chair of the council.

Marc Seale: Good afternoon. My name is Marc Seale, and I am the chief executive and registrar of the HCPC.

Q2 Chair: Can I ask first a general question about the scope of the work that you do? You cover a wide range of professions, some of them clinical, some avowedly non-clinical in the form of social workers. How well do you think that mix works and to what extent are you able to bring genuine professional expertise to bear in the regulation of those individual professions? *[Interruption.]* I warned you that the bells were about to go, and there they are. I will give you plenty of time to think about the answer to that question.

Sitting suspended for a Division in the House.

On resuming—

Chair: Very briefly, the question was on the breadth of scope and how effective you feel you can be across the full range of activities.

Dr van der Gaag 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.

Q3 Chair: Would it be fair to characterise it, in a sense, as 16 sub-regulators with an umbrella? What is the common element across the 16 professions?

Marc Seale: No, it is very not like that. 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.

I think there are three reasons for that. 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.

Q4 Chair: Do you think that there are lessons to be learnt by other professional regulators from the way you apply the principles you have just described?

Dr van der Gaag That is absolutely right. There certainly are organising principles that have application elsewhere.

Q5 Chair: Could you be a bit more specific? Offer your comparators some free advice.

Marc Seale: There is a trend going on in the regulation of health professionals throughout the world where multi-professional regulators are seen as advantageous compared to single regulators. We have a lot of contact with, for example, the Malaysians, the Singaporeans, the Republic of Ireland and, in particular, Australia, where they have gone from 96 separate organisations into a single regulator. As a group, the principles and

processes we use are very common. So there is a lot of cross-border work with the multi-professional regulators.

Q6 Chair: Taking the Australian example, does that cover everything from doctors through to social workers and equivalents?

Marc Seale: Not social workers; they currently are not regulated, but it covers the medics, the nurses, the physiotherapists—all the ones that we regulate. In Australia, it is not a responsibility of the federal government; it is devolved to the territories and the states. They have all adopted identical legislation in each jurisdiction, but they have a single register operated out of a single office in Melbourne.

Q7 Chair: I would like to get a better feel for this. First of all, do you think that would have attractions as an idea that should be explored for the UK? If you do, what do you think would be the practical consequences of that if you were somebody regulated by the GDC or the GMC or any of the others?

Dr van der Gaag We are certainly looking forward to the Law Commission Bill, which is going to bring much more consistency in terms of the legislative framework to professional regulation in the UK. From our point of view, that is very much a step forward. Health and social care are increasingly becoming integrated and the desire to see more integration from the public's perspective is growing. That message is growing in strength and influence. To have regulation that is integrated and is the same across all the professions resonates with what is happening outside regulation itself.

Q8 David Tredinnick: I want to ask you about something to do with drug and drink-related offences. The PSA told us it was disappointed that the HCPC has not accepted its recommendations that regulators should routinely request a health assessment for all registrants who are convicted of a drug or drink-related offence. Why was this?

Dr van der Gaag 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.

Q9 David Tredinnick: The breathalyser that the police administer is, some would say, quite random. There is a chance that those who drink and drive will get caught and a chance that they will not. Is there not a case for at least applying the same principle to those who have

been convicted and say that there is a chance that the HCPC will investigate and a pretty good chance that they will not. Surely it is worth applying some resources to keep them on their toes and protect the public?

Dr van der Gaag Absolutely, and we would investigate. What I am saying is that we would not necessarily apply a routine health assessment. We do not have provisions at the moment to do that, but we actually think that it should be a case-by-case analysis and a case-by-case decision.

Q10 Mr Sharma: In your written evidence you outline your approach to revalidation or "continuing fitness to practise". Do you believe your current system is sufficiently rigorous?

Marc Seale: We very much use the phrase "continuing fitness to practise" and we think there are three components. First, how does a professional maintain their continuing fitness to practise? Secondly, if you are asked to demonstrate it, how do you demonstrate as a professional that you are fit to practise? Thirdly, what should a regulator do to audit that process? We think it is very important to use those three components in how we look at our registrants' fitness to practise. Anna, do you want to go into more detail?

Dr van der Gaag If I may, I will expand a little on the system that we have adopted to give you a little of the rationale, then come back to your point about whether this is sufficiently rigorous. 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 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.

The other thing I want to say to provide an overview of the system is that we spent a long time engaging with the professions when we introduced these CPD standards. 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.

Returning to your point about rigour, we are much more aligned with some of the models of quality assurance and continuing competence in other parts of the globe than we are with the GMC's model. For example, in Canada the emphasis is on supporting the 5% of poor practitioners to improve, rather than the 95% of practitioners who the evidence shows do an excellent job. There is a difference here in the model, but our view is that it is rigorous enough and it encourages a dialogue about reflection and the outcomes-focused approach, which we believe has more of an impact on professional practice in the long term.

Q11 Mr Sharma: When you talk about assessors, are they independent assessors, or is it an internal organisation, with somebody from a different department doing the audit?

Dr van der Gaag They are our assessors.

Q12 Mr Sharma: So they are independent.

Dr van der Gaag They are independent from the registrant and the organisation that the registrant works with. They are trained by us and they carry out the assessments on our premises. It is an entirely independent process.

Q13 Mr Sharma: Do you plan to include patient input and feedback from appraisal within your system of continuing fitness to practise? What are the challenges associated with doing that across 16 different professions?

Dr van der Gaag This is a very important area and something that we have invested resources in. First, I would say 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.

We commissioned some independent research on this, and a very comprehensive review of very many different types of patient feedback tools. The very clear recommendation that came back to us from Picker Europe, which undertook the research, was that there is no one size fits all 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.

I think that is very much supported by a very large study commissioned some years ago and published in the *British Medical Journal*. In all, 11,000 health professionals and more than 30,000 patients were involved in that piece of work[1], and the conclusion there was—again—to be cautious about using one tool, because there is not going to be one that can provide genuine and valuable feedback on a practitioner's performance.

The other really important finding that came out of the Campbell study was that 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 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.

Q14 Mr Sharma: I accept that there is not one tool and that you have to choose many different tools, because I have some experience of working with learning disabilities. Have you got any tools in place, or are you still working on them?

Dr van der Gaag One of the tools that we have looked at is the care measure, which was developed by Stewart Mercer in Glasgow. That has now been validated with some of the professions that we regulate, with some success. That would be an example of a measure that we would certainly support. Again, I am caveating that by saying that it is not a tool that can be used in every context, but the care measure would be one that I would certainly very strongly recommend.

Q15 Chair: May I take you back to something you said in response to an earlier question from Virendra, that you thought that there were 5% of registrants where there were serious quality issues and that was where the focus needed to be, and then you actually said that the other 95% all delivered excellent care? I wonder whether you would like to reflect on that proposition. Is it not true in reality that there is a gradient? Should a regulator not also be interested in the professional culture right across the range of outcomes achieved, in order to strengthen the professional search for higher standards?

Dr van der Gaag I entirely agree with your last point. I was talking specifically about the evidence from around the world that shows that the number of professionals who come before fitness to practice hearings is very small. The number of complaints about health and care professionals, relative to the numbers on registers, is actually very small. I was talking specifically about the Canadian model, which focuses its quality assurance or continuing competence efforts on that 5%, rather than on the 95%. Nevertheless, I think that regulators have a very important role to play in influencing the culture.

Just to give you one example from our own work, going back a number of years we commissioned some research on professionalism, specifically because we were aware from our own analysis of fitness to practice hearings that the vast majority of complaints

[1] Note from the witness: The HCPC has supplied the following correction: 1065 doctors in 11 settings were involved in this work, and 30,000 patient questionnaires and 17,000 colleague questionnaires were used.

are about ethics, behaviour and conduct. If that is the case, then in a sense our responsibility as a regulator is to investigate that further and to initiate a dialogue with the professions about why that is happening and what can be done to improve or to prevent those sorts of conduct and behaviour issues from arising in other contexts. The professionalism research was done by an independent commission. The researchers were from the university of Durham, and they looked first at the definitions and people's understanding of professionalism. They asked students, those on the register and educators about how they would characterise professional and unprofessional behaviour. Through a series of workshops, both live and online, we took the results of that study to the registrants—we disseminated them widely—and used that research to generate discussion about professional and unprofessional behaviour.

Our aim was for there to be more debate and discourse about the issue, because in some ways it is easier to talk about a colleague's technical incompetence than it is to talk about behaviours that are perhaps unacceptable. That has gained a huge amount of traction. We have had a great deal of interest in the report—it is one of the most downloaded reports on our website—and a lot of very good feedback. I suppose that for us that is an example of how we are trying to influence and contribute to a debate about what constitutes good and not so good professional practice, which goes back to your point about influencing culture.

Q16 Barbara Keeley: Moving on specifically to the recommendations in the Francis report, a key issue to emerge was enabling the public and professionals to report concerns. I understand that you published some research suggesting that 73% of people would not know where to go to report worrying behaviour. Could you tell us more about that research and what action you want to be taken as a result of it?

Dr van der Gaag 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.

Q17 Barbara Keeley: Are there specific actions that you are taking based on the research or did that view that you have just given us tell you that it is all right really because when people need to know they can find out?

Dr van der Gaag 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.

Marc Seale: There is another bit of very interesting work. As a regulator the concern is always that the people who have issues and complaints are not making any contact with us and therefore are we failing because that information is not coming to us? A new bit of work has come out from something called the Health and Social Care Information Centre. It is only for one year and it only applies to England but it is essentially a breakdown of the complaints that have come in from the NHS in relation to the professions. Of the 110,000 written complaints that came in, roughly 50% are related to medical, surgical individuals; 22% to nursing and midwifery; only 4% to the allied health professions and, interestingly, 4% for the ambulance crews. Now, as a regulator we get very, very small numbers compared with the other regulators but it matches that other information which has been collected for another reason, which is people writing in complaints to the NHS. So if you triangulate those two bits of information, it indicates to us that individuals who need to raise issues about the people we regulate are getting to us in the right proportion because it matches that written information that is coming in to the Health and Social Care Information Centre.

Q18 Barbara Keeley: The Francis report highlighted the need for better joined-up working between different regulators. How do you plan to co-operate and collaborate with other organisations in future and do you think that the memorandum of understanding is sufficient? We have seen examples and talked them through here where an issue that should have been investigated got dropped between two regulators. Presumably there was a memorandum of understanding, but there have been examples, which the report highlighted, where it is just did not work between regulators.

Marc Seale: 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 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.

Q19 Barbara Keeley: That sounds like quite a big challenge, given the breadth of the professions that you cover. What difference does it make that you cover so many?

Marc Seale: If anything, I think it makes it easier, because we have a bigger presence, so people are more likely to know about us. Because we are a multi-profession regulator, and we are doing things differently in terms of how we operate, we have a constant stream of people from other countries coming to see us.

Again, there is a new thing that we are doing, and it is something that we have to learn about. Because the regulation of social work is a devolved issue—unlike with, say, physiotherapists—when we took on social work, we had to make the effort to go to Scotland, Wales and Northern Ireland to make contact with organisations that had more experience than us and more understanding of what was going on, and to ensure that those relationships work. But, no, if you are a multi-profession regulator, I think it makes your job easier than if you were a single regulator of a single profession.

Dr van der Gaag I would just add 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.

Marc Seale: Can I just chuck in one other thing, because I know that you have been talking to the other regulators? One of the issues that you have been raising is anonymous complaints—when the registrant or professional does not want to make contact. 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.

Q20 Chair: Is that unique to you in your regulatory field?

Marc Seale: I know my legislation pretty well, but I cannot give you an answer to that. However, one hopes that the very effective bit of Law Commission legislation coming down the road will be applicable to all the regulators. We would certainly be very disappointed if it wasn't, and I am pretty sure it is going to be in the new legislation from the Law Commission.

Q21 Andrew George: You have taken on responsibility for the registration and oversight of social work since August 2012. It appears to me, on the face of it, looking at the statistics,

that re-registration seems to have gone relatively efficiently. Taking on a profession with such a large number of registrants—83,500—what skills do you have? You talked about the benefits of being a multi-profession regulator, but what skills do you have to oversee and regulate social workers?

Marc Seale: When you look at an organisation such as ourselves as a regulator, there are two components. There is the expertise in running the infrastructure—do you have good IT systems, the right processes, the right esprit de corps within the organisation and the right culture that enables you to deliver regulation? But, if you are a multi-profession regulator, and if, let us say, you are approving a university programme, looking at an international application or sitting on a tribunal, you absolutely need the in-depth professional understanding of that profession, and that can come only from professionals. If you are a multi-profession regulator, how do you deal with that?

What we do is to have what we call our partners—about 800-plus individuals from the professions who work on our behalf when we need professional input to the process[2]. If you are sitting on a tribunal about a physiotherapist, you will have two physiotherapists on that tribunal. If you are approving a new social work programme, which we are doing at the moment, we run the infrastructure to make sure that individuals are trained and know what to do, but the visitors, as we call them, will be social workers. At the operational level, that is how we get the input from the professional element.

On other occasions there are what I call working groups. For example, when we brought the social workers on board, what standards should we have for that? We do not have any social workers in the organisation, so we set up a working group that is populated by members of the profession. The last equally important component is the governance arrangement. Anna, do you want to talk through that?

Dr van der Gaag 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.

The other thing that has been very important is that social work has been going through huge upheaval in recent years. For example, we have been involved in the Social Work Reform Board and the recommendations from that. We have supported those and are doing what we can as the regulatory body to implement them, working very closely with the professional bodies in social work so that there is an alignment there, which I think is very important.

Marc Seale: May I jump in? I think the other thing is that it is very much a two-way process. When we have brought the psychologists, the Hearing Aid Council, the operating department practitioners and the social workers on board, we, as an organisation, have

[2] Note from the witness: The HCPC has supplied the following correction: the HCPC has 634 partners.

adapted our processes. For example, when we took on the regulation of psychologists, we fundamentally changed some of our standards because they were very scientifically orientated—in fact, they did not fit in very well with groups such as OTs and arts therapists. It has to be seen as a two-way process. We have as much to learn about the profession that we are bringing in as a regulator as in the other direction.

Q22 Andrew George: On that note, do you accept that if you look across all the professions that you regulate—from biomedical scientists and paramedics and others—for which one might say that, if you had questions of professional competence or even malice that might be part of a complaint, one might argue that there is a way of objectifying the assessment of whether a person is competent to do the job or the complaint is upheld? However, in the area of social work, there is more likely to be a subjective judgment on whether they have correctly assessed a very difficult-to-assess human relationship. We know about circumstances in which some local authorities have taken children into care if they had a bruise, while in other cases you get a baby P scenario when they were prepared to take risks to keep family units together which, on reflection, was perhaps not wise. In those circumstances, do you not accept that some of the judgments that you have to make can be objectified and that others are deeply subjective? How do you as a body manage to cope with circumstances in which opinions may vary across the profession about how to deal with such circumstances?

Dr van der Gaag 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.

Again, we are at the early stage. Social workers came into regulation by HCPC last August. Clearly we have lots of learning to do, and we will be doing in-depth analysis of the cases as time goes on. If we look back at the cases that we have had, the numbers that are on the objective end of the spectrum are very small for all the professions. Again, going back to what I would call the conduct/competence split, last year only 8% of our fitness to practise hearings were entirely about what I would call technical competence or incompetence, and the rest were straight conduct issues or a combination of competence and conduct issues, so again you are getting that mix of the objective and subjective, and the judgments that these panels have to make are very complex, just as you describe.

Q23 Andrew George: In terms of the advice, you said that you appoint, or at least identify, a set of social work professionals whom you can call upon when you are seeking advice and dealing with the complaints that you are handling. How many are there, and how do you go about selecting people to act as your advisers?

Marc Seale: We select them by advertising in journals and communicating with the professional bodies, and through open competition. We recruit them against criteria and we give them a lot of training and retraining, appraisal and reappointment, and more training—we can never give enough training. That can be on the processes that we run,

changes in legislation and feedback from, let us say, court decisions or tribunals that we have undertaken, so it is a constant process.

At the same time, we have to make sure there is a reasonable turnover. You do not just want the good and the great from the professions sitting on your group, so we try to bring in the younger members of the profession to make sure it works. We regulate across Scotland, Wales, Northern Ireland and England, and we actively try to make sure that we get members of groups from the various countries. It is obviously more challenging if you are based up in Orkney, although in fact we do have someone who comes down from the islands, but it is a constant process.

Chair: And from Cornwall.

Q24 Andrew George: Cornwall; quite. It is the centre of the universe, so I am sure that it is well represented.

I was going to move on to the negative registration of social care workers. You are currently—this is the wrong term—toying with considering how you might achieve better oversight of the work of the 1.6 million or so social care workers, presumably especially those working in a residential setting. You are currently looking at the possibility of negative registration. Bearing in mind what the PSA has said—it does not currently appear to be terribly enamoured with or convinced by your proposal—and given the existence of the Disclosure and Barring Service in any case, as well as the role of the CQC, I wondered what added value there would be in creating a negative register?

Dr van der Gaag My understanding is that the PSA is interested in the proposals, but not yet convinced of exactly what part they would play. We are very interested in conversations with the PSA about that.

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.

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.

In relation to how that would interact with the disclosure and barring scheme, 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.

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.

Q25 Andrew George: One of the PSA's concerns is that there would not be a sufficient incentive; it is not reassured that employers would refer cases on. One could imagine that companies that employ care workers might fear the reputational damage from acting properly and referring matters to the police. Under your proposal, will there be a way of ensuring that referrals are handled in a manner that does not discourage employers from highlighting concerns about the behaviour or actions of their employees?

Marc Seale: We were quite surprised by the PSA's attitude to the proposals. 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 differentiate themselves from other organisations that do not put those services in place.

The other component is that many individuals on domiciliary visits are hired by individuals. They do not go into an organisation, but they go into an aged relation's house to deliver the service. We think that there should be standards, which are the core of regulation. We have put up proposals that show that this is an efficient, effective way—again, it is being run in other countries. It is not professional regulation, which is for individuals who do years of training, and have skills and expertise that are not understood by someone such as me, the man in the street; it is an occupational system. More of the service will be delivered, because it is a very efficient way of doing it, and we think it should be backed up by statutory standards. In the world of social care, which is where we were asked the question in the first place, Scotland is going ahead and doing this and Wales is consulting.

Q26 Andrew George: Sorry, about a negative register?

Marc Seale: About a negative register. We think we should move forward in England and put in a solution that works.

Q27 Andrew George: Will you explain how you would fund it? Is it something that the employers could fund?

Marc Seale: There is a fundamental difference between statutory regulation and a negative register. With a statutory register, you can charge professionals to come on to the register. 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. There is one of these systems up and running in New South Wales, in Australia, and the fitness to practise process is different because you are not approving university programmes, so the process is run at a much lower cost. 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. But the costs are fundamentally different.

Q28 Andrew George: I was going to suggest that it could be the care homes or the care companies, because presumably it would provide them with a degree of comfort and protection if they were to check their names through your negative register.

Marc Seale: Absolutely.

Dr van der Gaag Certainly, we have had conversations with big and small providers—the English Community Care Association, for example, as well as many other big private providers—and their view is that this would give reassurance that there is a mechanism for dealing with these serious and often serial offences against vulnerable individuals. The other interesting thing from them is that they 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.

Q29 Chair: Do you see this as a graduated series of standards? You drew the contrast between, at one end, the professional who has trained and committed themselves to a life in a particular profession; and, at the other end of the spectrum, the individuals who are helping in some way, who may be a part-time worker or, in truth, at least starting off by doing work in their own family. That is obviously a very wide spectrum. Should there be a graduated series of standards within the negative register as well?

Marc Seale: The way I would describe it is that there is everything from doing nothing, which doesn't cost anything, right through to full-blown statutory regulation, such as we as an organisation do. Then you have a range of options in between. You can have an entirely voluntary system, or it could be backed up by a professional body or association, but the negative registers are a possible fit in between. It is possible that some groups might then turn into professionals, but we think that in a sense it is part of the toolkit, and if it is appropriate it should be used in terms of the problem.

Also, if there is this trend away from treating people in acute care hospitals and facilities and the treatment is going to occur more and more in their homes, not outside, then you need a regulatory system that is fit for purpose for that new way of delivering the service.

Q30 Chair: I am not dissenting from that personally, but I was inquiring whether you thought there was scope within that concept of a negative register for more than one standard for different types of worker.

Dr van der Gaag Again, from conversation with Skills for Care, which has done a lot of work around standard setting, I certainly think that that is something that would be very

much worth considering. The modelling that we have looked at most closely, in New South Wales, has one set of standards—one code—which is very much about ethics, behaviour and confidentiality, but your suggestion of some kind of continuum could certainly be looked at and would be very valuable.

Marc Seale: Yes, it would work.

Q31 David Tredinnick: I want to ask about regulation of herbal medicine practitioners. The Government committed to establish a statutory register in the 2011 White Paper *Enabling Excellence*. It referred to a register of persons authorised to dispense unlicensed herbal medicines and proposed that we regulate herbal practitioners as non-medical public health specialists on a statutory basis. I shall go over a bit of the history of this, because I think it is important.

Professor Michael Pitillo, whom I knew well, produced in 2008 a comprehensive report on the regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK. He concluded, to quote from his report: "We are firmly of the view that, in the interest of public safety, statutory regulation should now proceed with all possible speed". Then, bringing things forward to 16 February 2011, the then Secretary of State, Andrew Lansley, announced that the Government would introduce statutory legislation and that this would be in place by April 2012, which was necessary to conform with the European legislation. I know that you are very much aware of this.

Coming up to July, I was lucky enough to initiate a debate on this subject, as you know. In that debate, Dan Poulter, the Under-Secretary, committed to setting up the new herbal practitioners and medicines working group, of which I think, Mr Seale, you are a member. Indeed, I have been asked to be a member and to vice-chair it, and to report back to the Minister on a regular basis under the chairmanship of the deputy chief medical officer, Professor David Walker, which I am really looking forward to. The first question is: could you update the Committee on plans to establish a statutory register for herbal medicine practitioners? And what input is the HCPC having in discussions to take that policy forward?

Marc Seale: The position of the council is that we support the regulation of this group. In fact, we support all the recommendations that Governments have made about regulating new groups.

Q32 David Tredinnick: Sorry, do you mean statutory regulation?

Marc Seale: Yes. And this also applies to where we have recommended groups that should be regulated, like the clinical perfusionists. The council has not changed our views; we think those groups should be regulated for the purpose of statutory regulation.

Q33 David Tredinnick: So your opening position is that you agree with Professor Pittilo.

Marc Seale: We support the Government's recommendation that they should be statutorily regulated.

Q34 David Tredinnick: Fine. Thank you very much for that. This is something that the new herbal practitioners working group will look at in some detail. It seems to me that, on the regulatory landscape, there is a slightly odd playing field. You have the Professional

Standards Authority for Health and Social Care regulating play therapy and sports rehabilitation, yet you, the HCPC, regulate art therapy and hearing aid dispensers. I know that you would say that it is a slightly different regime: oversight rather than statutory regulation.

Marc Seale: Yes, that is probably what I would have said.

Q35 David Tredinnick: Thank you. The PSA looks after the National Hypnotherapy Society and the British Acupuncture Society, whereas you deal with paramedics and operations department practitioners—I cannot read my notes, but it is something like that. That seems to be a rather strange muddle of regulation. Do you have a view on whether that is a satisfactory division?

Marc Seale: Absolutely, we have a view. I think it is very important to say that, in relation to the groups you mentioned, the PSA is not a regulator and it is not regulation. That is repeatedly said by Harry Cayton, and that is very important. It is an accreditation system.

Our view is that there are a range of professions that we have said very clearly should be statutorily regulated, but the Government, as we understand it, has decided that they should not be regulated. We are also concerned about the accreditation system. Our concern is that, by association, individuals imply that they are statutorily regulated by being part of the PSA accreditation system.

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 HPC was set up, we had a system in the UK where you had physiotherapists who were SR-ed—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.

Q36 David Tredinnick: I do understand the difference in the two regulatory regimes, and I have had many discussions with Harry Cayton.

Marc Seale: I am having a rant.

Dr van der Gaag My observation would be to agree that it is not a very logical landscape. I think the challenge is where you go. If you had a clean piece of paper and redesigned the system, you would do it very differently. But you have what you have and, in a sense, we have to move forward.

Our organising principle is around public protection. First and foremost, the regulators are there to ensure public protection for the professions that are regulated. Our view, as you would expect, is that this is the most robust system for ensuring that there is a way of holding individuals to account. Statutory regulation is, for us, the most effective and efficient way of delivering public protection.

Q37 David Tredinnick: It has been said—you may have alluded to it—that the Government have been moving away from statutory regulation towards voluntary regulation. My understanding from conversations with the Parliamentary Under-Secretary, Dan Poulter, is that he intends to leave it to the herbal practitioners and medicines working group to work this out. I think that all views will be given proper consideration in that committee. Let me ask you another question. Are there any financial considerations in the HCPC hoping to regulate herbal practitioners? Has it got anything to do with bringing in extra fees and the need for some kind of financial base? Is that a consideration? It has been a consideration with some regulatory bodies.

Marc Seale: From our perspective, we are not doing it for financial reasons. But when you look at what we would call an aspirant group, if you have a voluntary membership organisation, when they come into statutory regulation there is a financial challenge. The members of that group have to pay the registrant's fees and that group must be fairly well established, because many of those individuals will say, "Well I am now statutorily regulated, why do I need to be a member of the professional body or the voluntary association that I have been part of?" When we talk to aspirant groups we say, "Look, this is likely to happen. Will your organisation be strong enough to deal with the potential loss of memberships as statutory regulation is opened?"

The other component is that we have always argued, and the Government has very much supported us, that there is a cost of bringing a new group into regulation. We do not think that the existing professionals on our registers should pay for that, and the Government have always given us a grant to cover the costs of opening the register. That 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 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.

Q38 David Tredinnick: On the resources issue, very many years ago, I had the honour to serve in the House on the Chiropractors Bill and the Osteopaths Bill. I think one was in 1989 and the other in 1991 or 1992. They needed statutory regulation, which has made their bodies much more robust, and they have had a much better interface with doctors. One of the big issues was the huge bill that each practitioner had to pay each year. I think it was £1,000 in the case of chiropractors—

Marc Seale: It has come down now.

David Tredinnick: It was £600 for the osteopaths. The figures that you suggest in here are about £80, which is a very small fee.

Marc Seale: One of the documents that we gave you had a coloured graph at the back that shows that, in economic jargon, there are huge economies of scale: the bigger your register, the lower your costs. The reason we can charge an £80 registration fee is that our register has 320,000 individuals. When we bring a new group into regulation in a sense you are coming into an organisation that is set up, so you don't have to pay the start-up costs. The chiropractors and the osteopaths had to start with a blank bit of paper, which required them to put millions of pounds into the system to get it up and running. That is why you get the dramatic differences in cost.

Q39 David Tredinnick: It took many years to get right.

Marc Seale: It took many years, yes.

Q40 David Tredinnick: But by bringing all the groups together under a regulator the osteopaths have produced a much more robust system. There are many fewer individuals, not that there were many in the first place, who were suffering from poor practitioners. There are always very few, I should say.

Marc Seale: A good example is when the Hearing Aid Council was wound down and brought into the HCPC, the registration fees, which were £675, came down to £76.

Q41 David Tredinnick: So I put it to you—a slightly leading question—that anybody who is a herbalist, and there are many in this country, or is practising ayurvedic or traditional Chinese medicine would be very encouraged to hear the low level of fees that would be proposed by the HCPC.

Marc Seale: That is correct.

David Tredinnick: Thank you. If I may, Chair, I have two further lines of questioning.

Q42 Chair: Before you go on, David, I will just ask a supplementary on the economics. One of the major differences is that at the HCPC at you are just under £100 per registrant on just over 300,000 registrants and the GMC is on £400 per registrant on, say, 250,000 registrants. Those are the two major outliers. Does that reflect quality or cost?

Marc Seale: What I will do is dodge that question and refer to a very good document produced by the PSA. A couple of years ago, I think, it basically took all our financial numbers and stacked them up so you can make comparisons between the two. They got a bunch of economists from Oxford. It was a very good report and it essentially shows that these economies of scale apply to each of the functions of regulation. It also puts forward an argument about what I think it called the "intensity" of regulation. The argument was that because of the complexity of what they do, the cost of regulation for some professions is going to be higher. We did not agree with that argument. We think that some of our professions are pretty intense, but it is a very good report. I am sure that it is on our website.

Q43 David Tredinnick: In determining your view that there should be statutory regulation of herbal practitioners, did you have a chance to look at the international scene and what is going on in other countries? In particular, I was wondering whether you had looked at the system in India, where an organisation called AYUSH is the regulatory body that covers ayurvedic medicine, yoga, homeopathic medicine—

Marc Seale: The only one I am familiar with is the Australian regulator—

Q44 David Tredinnick: Which is a statutory system.

Marc Seale: Because they brought it into the system. Unfortunately, that is the only one I am familiar with.

David Tredinnick: In Singapore I think it is statutory, too.

Marc Seale: The other area is Hong Kong, where within the constitution there is provision of traditional Chinese medicine. We have seen the systems in operation. Interestingly, their legislation is quite similar to ours, given the history of that part of the world. I am not familiar with how it works in India.

Dr van der Gaag Certainly there are lessons to be learned from regulatory systems elsewhere. We have very much adopted that principle and we would apply it here should this be taken forward.

Q45 David Tredinnick: Earlier, Mr Seale, you were talking about economies of scale and you, Dr van der Gaag, talked about organising principles that have applications elsewhere. The theme was that having a large number of organisations with the same regulatory modus operandi was the way forward, because it made for better and less complicated regulation. I think you said that, Mr Seale. I put it to you that with health and social care coming together, it is all the more important that we have a playing field where the regulator has similar standards for everybody across the field.

This is an important way forward. I am thinking particularly of a meeting being held tomorrow by the Science and Technology Committee, of which I am fortunate enough to be a member. At 9.30 tomorrow morning, we are looking at antimicrobial resistance and the whole problem of antibiotic resistance. It is clear from the views of Dame Sally Davies in her book, *The Drugs Don't Work*, that we have a major problem in terms of recreating and bringing on new antibiotics, and drug companies do not want to invest. The efficacy of current drugs is wearing thin. Your work will become more important, because rather than tackling the demand for antibiotics through people wanting more and more new antibiotics, the other way of dealing with it is to reduce the demand. To do that, we are going to have people using other medical systems—acupuncture, herbal and homeopathic medicines used widely in India, France and the United States, and to do that, we need proper statutory regulation. We need firmer regulation. It is not for me to say whether it is statutory. You put forward a view, and the herbal practitioners and medicines working group is going to look at this. I would suggest to you that, if we have this crisis in antibiotics, it is more important that we have firm regulation of other therapies, which could form a replacement or at least assist in the problems associated with antimicrobial resistance.

Dr van der Gaag Absolutely. To go back to our original point, we welcome the Pittilo report. We looked at it in great detail when it was published in 2009. As a council, we endorsed what Pittilo recommended.

Chair: Barbara wants to talk about public health.

Q46 Barbara Keeley: You have been asked to take on the statutory regulation of non-medical public health specialists. We have had some evidence from the UK Public Health

Register, which currently runs the voluntary register. They have talked about you not engaging with them about the development of that Government policy. They also argue that they believe that population-based occupation, such as people who work in public health, require more specialised competence. They think that that is an issue. They also have concerns that you do not support dual registration. They feel that because of the nature of public health and the different professions that are represented, having to choose between professionals will cause fragmentation. Those are the issues that they raised. How would you respond?

Marc Seale: I was a bit surprised. My colleagues have been working on the public health work force advisory group with the author of the letter. We have been working with them since that was established.

I think there is a degree of frustration, as I have explained, that as a sort of public organisation, we cannot put resources into, for example, deciding what the standards are until we are absolutely sure that the Government are going to hit the go button and we are going to see the legislation. If we had done that, we would have wasted a huge amount of—

Q47 Barbara Keeley: So you are waiting for legislation to go ahead?

Marc Seale: 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 or 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. In relation to dual registration, I am sorry, but I could not understand the point they were making. It is an area—

Q48 Barbara Keeley: I think they just want you to support dual registration. That seems to be the point.

Marc Seale: Again, we have said that we support the Government's recommendation to bring in statutory regulation. I think it has been a frustrating process for them, because we have had the Law Commission work coming out, and I think they have been told, "It is going to happen next month. It is going to happen next month." It has been delayed, and it has been quite a frustrating process, but that is no different from any other group that has been brought into statutory regulation.

When we brought in the psychologists, they had started looking for statutory regulation in the 1960s. It took them just over 50 years to get into the system. The frustration is real, but relatively, they are doing pretty well.

Q49 Barbara Keeley: I suppose the next point is a follow-on. We have received evidence from the Registration Council for Clinical Physiologists that their profession should be subject to statutory regulation. They believe that their role involves carrying out procedures that would "pose serious risks to patients if not carried out with the highest professional

standards". What is your position on that? If you like, you can widen it to the other professions.

Marc Seale: It is exactly the same. It is a group that we have supported. This particular group, we have in fact recommended should be regulated. The Government have decided that they should not be statutorily regulated. We disagree with each other; they should be brought into statutory regulation. They are a very important group. They have scientific training, and they should be brought into statutory regulation—no question about it. If you are regulating clinical scientists and biomedical scientists, why are we not regulating that group? I do not understand.

Q50 Andrew George: If the purpose is public protection, where does this end? Why not regulate witch doctors?

Marc Seale: In terms of health, there are probably about four or five groups that we have recommended should be brought in, but there are not another 30 or 40 groups out there ready to be brought into the system. I think that that is a concern. Also, you have to be concerned about the downside to statutory regulation, which is that it puts up the cost of professionals' wages. You have to balance the cost of wages going up versus the benefit. But it is not like that there is this other group—

Chair: It also implies that there is a quality of service that the state is willing to endorse, which probably does not apply to witch doctors.

Dr van der Gaag 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. I am not saying that witch doctors are necessarily on that spectrum, but 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.

Q51 Andrew George: But is there not a risk, in relation to public protection, that by introducing a particular activity into statutory regulation, you are by implication suggesting that there is an evidential base to show that the activity is in some sense effective, when it might not be?

Dr van der Gaag That is the debate. That is why, every time we look at a new profession that has come to us—over the years, we have had 53 inquiries from very different professions asking to be brought into statutory regulation—one of the criteria is on the body of knowledge and the evidence base of the particular discipline. We do take it into consideration and it is one of the criteria that we used when we were considering the question.

Q52 Barbara Keeley: So of the six that you made recommendations to bring in—I mentioned clinical physiologists—is there anything to choose between them? Would you say that clinical physiologists are a priority, or that one of the others is more of a priority?

Marc Seale: Actually, I speculated about whether we would get this question and what would be the way to answer it. If you had, let us say, four groups, and one was very large and one was very small, my view is that, in terms of achieving maximum protection in the shortest possible time, you would bring in on day one the biggest group in terms of the largest register.

Q53 Barbara Keeley: And is that clinical physiology?

Marc Seale: We have not actually sat down and done it because we have made these recommendations as they have come through, but if there was a situation where the Government said, "Look, there are four groups, what do we do?", I would certainly say, "Let's do the biggest group first."

Q54 Barbara Keeley: I think they have said that they have about 5,000 registered.

Marc Seale: Yes, whereas the clinical perfusionists, say, have a very, very high-risk undertaking, but there are only about 300 or 400 of them, so even though they might be upset, I would do the big group and then the little groups later on.

Q55 Chair: You have used the argument more than once that the motivation is public protection. However, the point came out in Andrew's questioning that it is not just about safety and protection, is it? Is it not also about the state endorsing a particular profession as delivering something of value?

Marc Seale: I think that the heart of it is, in fact, the standards. What we can do as a regulator is set those standards in both education and proficiency and then, over time, working with the profession, adapt and improve them. To me, that is the heart of regulation.

Q56 Chair: But there is no point in Parliament providing a statutory regulatory framework for a profession for which there is no evidential base, is there? That is the state endorsing something for which there is no evidence of value.

Marc Seale: Regulation is a huge badge of respectability, professionalism and endorsement—absolutely. That is why hundreds of groups across the globe would like to be brought into a system where the state gives either them or a regulator those powers. I think it is very important to balance why we are doing this—is it really going to be of benefit?—if it is, then make that decision.

Q57 Chair: And it links back to one of the points we were discussing earlier around the 95%. How can you improve value if there is no evidential basis for the proposition that there is any value there at all?

Dr van der Gaag I would just make an observation on that. There is the sense that this is a kind of either/or. I think it is much more nuanced than that. If we talk about the evidential base of the profession, people will have very different opinions about the nature of that evidence and whether they accept it as evidence or not. That is why this is such a

difficult area to get into because there are very different views about whether, for example, 3,000 years of case studies, a lot of them in Chinese, are considered an evidential basis. Clearly, in some parts of the world and in some communities it absolutely is and in others, it is not. That is why we are back to the cliché of the devil is in the detail. I am not sure that the evidential base can be so pinned down and used as the key imperative in decision making. For me, that is why it comes back to public safety. One element of the decision-making process has to be the evidence and the body of knowledge of that profession, but it is not the only one.

Q58 Chair: But you can conceive of offering statutory regulation of a group of people where—suppose as a thought experiment that there was a set of people where it was accepted by consensus, not necessarily by everyone, people can have opinions, but the general scientific evidence was that the service offered by these people delivered no benefit to patients. Should those people be regulated by the state?

Dr van der Gaag If it is as definitive as that, if there is no benefit, then no. Clearly, there has to be a line there.

Chair: I take your point that there would be differences of view, but ultimately when Parliament legislates it makes a decision.

Q59 Andrew George: Not only that, but there may be circumstances where even if it is disputable that there is an evidential base that this particular activity, or remedy or type of treatment is effective, the fact that it has a statutory regulation will send a message to a patient that it may be effective, for example, to take a supplement or herb rather than going for surgery for cancer. Where is the public protection there?

Marc Seale: If you look at what is happening in bringing groups into regulation, the decision to regulate paramedics was relatively straightforward and I think not many people would say, "Well, actually, paramedics should not be statutorily regulated". Not only in this country but in other countries when you get into this area of herbal medicine, for example, what seems to happen is that Government sets up an inquiry, has another group look at it, then there is a bit of a gap, then another group looks at it, and it just goes round and round in circles because of this central dilemma.

There is a scientific community at one end of the spectrum which says, for a sense of respectability, there is no evidence, so you should not be regulated. At the other end of the spectrum, you have public protection and the argument that I would use that people do use these systems and they should be regulated. There is a huge conflict of interest between those two groups. The Government tend to say that we now need another working group and we go round the loop for the next five years. Over the past 20 or 30 years I think there have been about five or six Government-funded or triggered groups looking at the question. Every time it is called for about five years, and then we have another one.

Q60 Chair: Can I take us down a slightly different route very briefly before we close? What does good regulation look like in terms of the handling of fitness to practise procedures? If you receive a complaint against a registrant, what is your objective in terms of the time scale taken to determine it from the point of view of either the individual patient or the registrant?

Marc Seale: Can I just give a little background to this, because I know that similar questions have come up in your meetings with other regulators? The fitness to practise process is a two-stage process. There is the investigation stage, when we essentially ask ourselves, "Is this an issue that we need to address?" If we say yes, there is the second stage, which ends in the tribunal. What we are very concerned about as a regulator is: how long does the first process last, how long does the second one last and how long are the two combined? If you are a registrant and you are involved in this process, or if you have made a complaint, you are very interested in that length of time. But—and there is a "but"—quite a high percentage of the complaints that come in at the early stage—maybe 40% or 50%—are dealt with in two or three months, which is a very short period of time. So if you ask, "What is the average length of time"—

Chair: I didn't.

Marc Seale: I know.

Q61 Chair: Let me ask another question: what is the maximum?

Marc Seale: When people ask what the average length of time is, I throw my hands up in despair, because it is a meaningless number. What we have to look at is how long it takes for cases to go right through the process. I have the numbers in front of me, but may I just look them up so that I can give you the exact ones?

Chair: Either that or write to us. As you rightly said, it is a subject we have pursued with the NMC—that is the reason why I asked the question of you.

Dr van der Gaag Perhaps I could come in while Marc is looking up the numbers—

Marc Seale: I have the numbers now. In terms of the first stage, the mean is currently about seven months and the median is about six months. For the complete process, we are currently running at about 18 months at the mean and 16 at the median. It has gone a little bit; we are actually a little too long. We would, ideally, like to go down to about five months. What we need to do as a regulator is to deliver public protection while at the same time looking after the human rights of the registrants to make sure that this is a fair process.

Q62 Chair: There is an old adage about justice delayed, isn't there? It would be helpful to the Committee if you could send us the evidence about not only means, but the longest cases.

Marc Seale: Yes. We will get some very long outliers, which we do not want, but they do happen every now and then.

Chair: It is the Jarndyce and Jarndyce syndrome—Dickens.

Q63 David Tredinnick: Can I just go back for a moment to the question of what is evidence? You talked about the Chinese saying that there are 3,000 years of reporting of a particular—probably herbal—acupuncture method and hinting that we should perhaps look at that. Here we have a scientific community that says that if something has not been proven using a double-blind, placebo-controlled, randomised trial, it has no value. NICE has now approved acupuncture for lower back pain, which is to be welcomed, because a lot of people benefit from it. However, I have used acupuncture over the years for a whole range of other

things, and I am sure it works. I have looked at Chinese studies that go back to some of the great Chinese philosophers. Have we not got to a ludicrous situation where we ignore the evidence of people getting better when they have a particular treatment? When we, as politicians, have people come to our surgeries, we have to make assessments of them, and it is perfectly possible to assess whether something has worked without having a double-blind, placebo-controlled trial. Is it not important that we look at the evidence of what has happened to people, as well as insisting on these trials? We have got to a point where we are not using the available medical systems effectively because we have got so wrapped up in this concept of double-blind, placebo-controlled trials.

Dr van der Gaag Certainly, if you look at the really excellent work that the Pittilo working group did on this, there are different kinds of evidence across the range of interventions.

May I come back to your really interesting, important point about what good fitness to practise looks like? We have done a lot of work on the operational side and have also engaged with registrants, the public, employers, educators and so on about the meaning of fitness to practise. Perhaps one of the things that is often missing is a shared understanding of what the fitness to practise process is there to do. Although, on the face of it, it seems very obvious, I think there is still work to be done by all of us in getting a shared understanding of what fitness to practise is there to do. It is not a complaints resolution process, for example, and it is not there to sort out people's frustrations about hospital car parking fees. It has a very specific meaning in professional regulation: it is about whether somebody continues to meet certain standards of conduct and competence, and whether there is a finding of impairment against those standards.

Part of the process of improving efficiency and effectiveness in professional regulation is about getting that shared understanding so that people's expectations of what they are coming into, whether as complainants or witnesses, are understood. That has been a big focus for us over the past few years, and I think it has been well received in the community that we operate in.

Chair: I think it would be helpful if the note you are going to send us about the statistics could also say a bit about the approach you take to fitness to practise—perhaps enlarge a little on those thoughts—because it is one of the points of comparison between the work that you do and probably your most direct comparator in cost and numbers terms: the NMC.

Thank you very much for this interesting session.