



Confidence in Care

Programme Initiation Document

PROGRAMME INITIATION DOCUMENT

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1. Strategic Context

The Department of Health 's (DH) White Paper "Trust, Assurance and Safety" published in February 2007 sets out a programme of reform to the United Kingdom's system for regulation of health professionals, based on consultations on the two reviews of professional regulation published in July 2006:

- *Good doctors, safer patients* by the Chief Medical officer for England, which was a comprehensive report examining medical regulation in its broadest sense and
- The Department of Health's "The regulation of the non-medical healthcare professions".

The primary purpose of professional regulation is to ensure patient safety. As such it is a vital component of the overall framework in the United Kingdom for ensuring the highest quality health care for the public. In Northern Ireland careful consideration must be given to the interface between health and social care within the integrated model.

The White paper is also complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry, the recommendations of the Ayling, Neale and Kerr/ Haslam inquiries, as contained in 'Safeguarding Patients', which sets out a range of measures to improve and enhance clinical governance in the NHS.

In Northern Ireland the DHSSPS published their response and action plan to the Shipman Inquiry recommendations in the document "Improving Patient Safety: Building Public Confidence" in November 2006. A mapping exercise has been carried out to determine the outstanding recommendations of this report and the associated recommendations from HM Government publications "Safeguarding Patients" (Feb "2007) and "Learning from tragedy, keeping patients safe" (Feb 2007). The implementation of these recommendations will be addressed within

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this programme. It is envisaged that the work of the following established NI Shipman subgroups will be subsumed in the revised Confidence in Care work streams as outlined below

Existing Shipman Subgroups	Lead/ Contact	Proposed Confidence in Care Workstream
Accountable Officer Subgroup	Norman Morrow, John Farrell	Pharmacy Group
GP Data analysis subgroup	Kathryn Booth / Gillian Harkness (EHSSB)	Tackling Concerns Locally and Nationally
Enhancing prescribing in General Practice	Kathryn Turner - CSA	Tackling Concerns Locally and Nationally
Improving Governance in Single Handed GP practices	Discussions underway with Western Health and Social Services Board	Tackling Concerns Locally and Nationally
The Education Framework	Diane Taylor	Revalidation and Education
Whistle Blowing in General Practice	John Farrell	Tackling Concerns Locally and Nationally
Management of Underperformance in General Practice	Paddy Woods	Tackling Concerns Locally and Nationally
Improving Governance for sessional doctors	Discussions underway with Northern Health and Social Services Board	Tackling Concerns Locally and Nationally

The White Paper proposes a number of reforms for the modernisation of professional regulation. The aims of the reforms are to ensure that health professionals, throughout their careers, are able to assure themselves, their patients/ clients, colleagues and employers that their commitment to practise to the highest standard is underpinned by objective confirmation of their

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competence to do so. It also recognises that there are a number of new roles emerging in health care that may require registration with a regulatory body in the near future.

The White Paper notes that the Devolved Administrations are committed to regulation across the UK, including in the professions new to regulation. It is however recognised that in terms of operational practicalities some of the proposals will need to be considered by the Northern Ireland Assembly. These local arrangements will need to enable health professionals to move easily around the UK during their careers. It is likely that pilot exercises will be used to test and evaluate some of the proposed approaches to implementation.

Equally the White Paper recognises that public trust in the professionals needs to be sustained by ensuring that the nine regulators of healthcare professionals in the UK, i.e.

- The General Medical Council,
- The Nursing and Midwifery Council ,
- The Health Professional Council,
- The General Dental Council,
- The Ophthalmic Society
- Pharmaceutical Society of Northern Ireland,
- Pharmaceutical Society of Great Britain
- General Chiropractic Council
- General Osteopathic Council

provide objective scrutiny of the practitioners from the perspective of reasonable patient/ client expectation and free from any doubt that the regulators are overly sympathetic to lapses in conduct or competence through a sense of professional loyalty. The White Paper's key proposals for reform are outlined in **Appendix 1**.

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In summary the White Paper is based on five key principles

1. The overriding interest of professional regulation must be the safety and quality of the care that patients/clients receive from health professionals.
2. Professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of Government, the professions themselves, employers, educators and all other interest groups that impact on healthcare.
3. Professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professional as it is about identifying and addressing poor practise or bad behaviour.
4. Professional regulation should not create unnecessary burdens, but should be proportionate to the risk it addresses and the benefit it brings.
5. There is a need for a system that ensures the strength and integrity of the health professions within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within NHS England, Scotland, Wales and Northern Ireland and to adapt to future changes.

To take forward the requirements of the White Paper the Department of Health in England has established a range of working groups. While interim arrangements have been made for suitable representation from Northern Ireland on these groups this will need to be revisited in the longer-term.

Current proposed groups are:

- **Medical Education and Revalidation;**
 - ❖ Current NI representative – Carolyn Harper (Deputy Chief medical Officer, DHSSPS)
- **Non-Medical Education and Revalidation;**
 - ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)

- **Tackling Concerns Locally** – which would include consideration, for example, of the proposal for GMC Affiliates, the role of the Medical Director, Death Certification, Performers List, Alert Letters and the local management of information;
 - ❖ Current NI representative – Paddy Woods (SMO)

Nationally a number of groups have been established under the Tackling concerns locally banner. These are:

- I. GMC Affiliates group – Lead - Paddy Woods
- II. Responsible Officer group –Lead – Paddy Woods
- III. Clinical Governance group – Lead (to be agreed)
- IV. Information Management group - Lead (to be agreed)
- V. Death Certification group – Lead Heather Neagle
- VI. Performers List group – Lead John Farrell

The ongoing work and outcomes of these subgroups will be picked up and included in the Tackling concerns nationally and locally subgroup.

- **Tackling Concerns Nationally** – which includes consideration of an independent adjudicator;
 - ❖ Current NI representative – John Farrell (Principal Officer general medical services, DHSSPS)
- **Enhancing Confidence in Healthcare Professional Regulators** – covering governance arrangements for the regulatory bodies;
 - ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)
- **Health of Health Professionals**
 - ❖ Current NI representative – Kathryn Fodey (Nursing Officer, DHSSPS)
- **Extending Professional Regulation.**

- ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)

In addition there is a **Pharmacy Regulation and Leadership Oversight Group** (PRLOG), chaired by Ken Jarrold, allied to the establishment of a General Pharmaceutical Council. Representation from Northern Ireland is provided by Norman Morrow, Chief Pharmaceutical Officer (DHSSPS), the President of the NI Pharmaceutical Society and Ms Tracey Boyce, Director of Pharmacy, SHSCT.

Pharmacy Regulation in Northern Ireland

The Minister has yet to make a final decision on the future of the Pharmaceutical Society of Northern Ireland (PSNI). However, he has indicated that he is going to wait until the General Pharmaceutical Council (GPC) is established in Great Britain; Current timescales would propose this new body would operate in shadow form in 2009 and become fully operational by January 2010.

The Minister has also indicated that in developing new arrangements for the future the Department will continue to work with the PSNI and other relevant bodies to ensure that patients/clients and the public are fully protected. The Department is therefore committed to changes in the current legislative provisions underpinning the PSNI and will be further informed by the Council of Healthcare Regulatory Excellence allied to its current performance review of the PSNI, published in [August 2008](#).

Deleted: August 2008

In either event i.e. the incorporation of PSNI into a UK wide GPhC or the continued existence of PSNI as a separate regulator this is likely to have legislative resource implications for the programme. To this end a Pharmacy group will be established within the Confidence in Care programme to take forward these areas of work.

1a Interface with Social Care

The Northern Ireland Social Care Council (NICSS) is the regulatory body for the social care workforce in Northern Ireland. Its aim is to increase the protection of those using social care services, their carers and the public. NISCC was legally established on October 1 2001 by the Health and Personal Social Services Act (Northern Ireland) 2001. It is a non-departmental public body, sponsored by the Department of Health, Social Services and Public Safety (NI).

An exercise has been undertaken by the DHSSPS to compare the White Paper recommendations against current NICSS activity.(attached as **Appendix 2**) The actions from this exercise are currently being addressed by the Office of Social Services of the DHSSPS, however issues regarding the future regulation of the wider health care support and social care workforce as per section 2 paragraph (3) of the Health and Personal Social Services Act (Northern Ireland) 2001 (attached as **Appendix 3**) will require further dialogue and action.

In addition consideration should be given to linkages with the new Independent Safeguarding Authority (ISA) whose aim is to prevent unsuitable people from working with children and vulnerable adults. The scheme is scheduled to go live on 12 October 2009.

1b Legislative implications

9. The Health and Social Care Bill, which includes elements of the White Paper proposals, was introduced at Westminster on 15th November 2007. The Assembly demonstrated support to the full content of the Bill by agreeing a legislative consent motion on 14 January 2008.

The Bill received Royal Assent in July 2008.

Deleted: Bill received

The areas within the Bill which will extend to Northern Ireland are attached as **Appendix 4**

2. Programme purpose and Objectives

The purpose of this programme is to contribute effectively to policy formulation nationally associated with the requirements outlined in the White Paper “Trust, Assurance and Safety” and ensure that the proposals of the established working groups are successfully implemented in Northern Ireland. The programme will also address the work of the PRLOG Group and ensure the implementation of the outstanding recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from HM Government publications “Safeguarding Patients” (Feb “2007) and “Learning from tragedy, keeping patients safe” (Feb 2007)

2a Overarching Objectives

The overarching objectives of the programme are:

- To ensure effective engagement as appropriate with the Minister.
- To ensure, through robust programme management, that the recommendations of the working groups are successfully co-ordinated, implemented, monitored and evaluated in Northern Ireland.
- To identify and action any short term measures required pending the outworking of the working groups including outstanding work associated with the outputs of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe”

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- To ensure effective representation, and quality of input, from Northern Ireland into the working groups and harmonisation of the regulatory framework in Northern Ireland.
- To ensure there is effective communication with key stakeholders throughout Northern Ireland, taking account of the diversity of professional roles and locations and the integrated structure of health and social care.
- To quantify the resources necessary to support the running of the programme and ensure that they are allocated appropriately
- To develop a business case for any resources to support the effective implementation of the programme.

Each of the working groups will also have a clear set of measurable objectives to deliver against. (Initial thinking attached as **Appendix 5**)

3. Programme Scope

The programme will address all actions arising from the White paper based on outcomes from the DoH working groups. While this does not include the implementation of the associated legislative framework nationally, action in respect of the role of the Assembly and Executive in this regard will form part of the work of the programme. The assurance of independence of professional regulators will be undertaken nationally by the Department of Health, England. The programme will also encompass the implementation of any of the outstanding recommendations from the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” (Feb “2007) and Learning from tragedy, keeping patients safe” (Feb 2007)

The programme will not directly address social care which remains the responsibility of the NISCC. The DoH is planning to publish a report later this year on the regulation of Health Care Support Workers in addition to a pilot scheme in NHS Scotland. Issues regarding extended workforce regulation will require continued co ordination and dialogue and this will be addressed by the group charged with ‘Extending Professional Regulation’. There will also be senior

representation from the Office of Social Services on the Programme Board who will be accountable for the identification and translation of recommendations as appropriate from the working groups into the work of the NISCC.

4. Programme Deliverables

This section is based on the key deliverables currently identified in the individual White Paper working groups and the outputs of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe” The advice of the working groups will enable more detailed characterisation of the key deliverables to be developed for each workstream and these will be refined over time as implementation plans proceed.

4a Medical Revalidation and Education

- A comprehensive system of appraisal in Northern Ireland using multi source feedback which will be sufficiently robust and consistent to inform reliably a UK wide system of revalidation
- In undertaking this work the groups should take due regard of the regulatory arrangements for medical staff within the Irish Republic.

In addition this working group will need to advise on the implementation of the delivery of the White Papers proposals for medical education.

4b Non –Medical Revalidation

- Formative and summative appraisal arrangements for the non – medical professions in Northern Ireland which are sufficiently wide-ranging, robust and consistent to inform reliably a UK wide system of revalidation.
- Generic and profession specific identification of areas where risk necessitates further assessment approaches over and above appraisal and development of appropriate standards and assessment methodologies.

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- In undertaking this work the groups should take due regard of the regulatory arrangements for non-medical staff within the Irish Republic.

4c Tackling Concerns Nationally

- Proposals and protocols for sharing information about registrants with the public, patients, employers and other interested parties and an extension of the range of actions available to regulators when they have identified concerns, so that , where appropriate, the options of rehabilitation, remediation and retaining are more readily available.
- Clarification and agreement of the role of the Council for Healthcare Regulatory Excellence in ensuring fair, effective and consistent fitness to practise arrangements and a move to a common standard of proof across professionals

4d Tackling Concerns Locally

- The development and implementation of new arrangements for the roles and responsibilities of a UK network of GMC Affiliates and Responsible Officers
- The review and, if necessary, redesign of the Performers' List system;
- The review and development of systems for collecting and using information on health professionals for complaints, investigations and disciplinary measures
- The design and implementation of a new system of Death Certification for the United Kingdom.

4e Enhancing Confidence in Healthcare Professional Regulators

- Measures to provide assurance to the public, patients, the professionals and the Assembly that Councils are operating fairly and effectively in the exercise of their duties

4f Extending Professional Regulation

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- The development of criteria against which all roles in the United Kingdom will be judged to determine which should be statutorily regulated and the priorities for doing so.
- Future regulation of the wider health and social care workforce
- In undertaking this work the groups should take due regard of the growth in integrated health and social care working patterns throughout the UK and of the integrated health and social care structures in Northern Ireland, alongside plans for registration and regulation of the social care workforce in each of the four countries

4g Health for Health Professionals

- The development of an integrated national strategy for the health of all health professionals including the piloting and evaluation of referral services for doctors which will inform the remedial and rehabilitative aspects of fitness to practise and revalidation outputs

Outstanding Recommendations

The recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe” have been mapped against the proposed working groups. and are attached as **Appendix 6**

5. Constraints

- Resource requirements have not been determined at this stage, but from the DoH, Partial Regulatory Impact Assessment of the White Paper, benchmarking from other regions and discussion with key stakeholders, appears to be significant
- Availability of adequate resources for programme and project management
- Availability of Departmental and HSC staff to lead and populate project teams

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- Timescales for this programme will be primarily driven by the National framework

6. Assumptions

- The national element of the legislative framework will be managed by the Department of Health, England.
- Appropriate local representation on working groups

7. Interdependencies

Most of the working groups will have interdependencies and connections with the other groups. This will be addressed by ensuring

- Appropriate representation on programme board
- appropriate cross-membership between working groups,
- regular formal meetings of the project managers ,
- circulation of Programme Board minutes and updated Programme plan.

8. Benefits

- Compliance with the recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe”
- The timely, effective and affordable introduction of a revalidation system comprising relicensure and recertification of doctors.
- Each regulator will develop the standards that a registrant will need to meet to periodically maintain their registration.
- The education function of the GMC would be brought into line with the operating methods of Post Graduate Medical Education and Training Board (PMETB). (The PMETB through its founding order has a wide range of interests on its Board including lay members, patients and the NHS).
- All professional staff will be recorded on a live register.

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- Greater emphasis on remediation, rehabilitation and support for those health professionals who are experiencing difficulties.
- A legal practical way in which all health professionals could reach an appropriate standard of English language proficiency.
- The improved safety of patients, with lower risk of potential exposure to abuse, incompetence or unacceptable behaviour.
- A strengthening of the process through which health care organisations learn from mistakes and strive for continuous improvement in the quality of services they deliver.
- The development of criteria against which all professional roles in the UK will be judged to determine which should be regulated.

9. Programme infrastructure

The programme will use a structured programme management approach in line with Prince 2 methodology and 'Managing Successful Projects'.

9a Resource Requirements and Benchmark Data

Programme support will need to be kept under review as the Programme develops, however experience would suggest that this will be significant. Evidence from Scotland indicates that there is a clear requirement for a dedicated management team to take forward the programme i.e.

Professional Regulation Programme Team - Scottish Executive

Grade of Staff	Current Establishment	Additional Requirements
Head of regulatory unit – C1	1.0 WTE	No Change
Policy Officer B2	1.0 WTE	1.0 WTE
Personal Assistant	Nil	1.0 WTE

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Administrator	0,5 WTE	Nil
Professional Advisor – NHSS secondee	1.0 WTE	1.0 WTE

The Welsh implementation team, who are also at the set up stage, have recently gained approval for a secondee at Executive Officer level to assist with their project for the next number of years.

The Department already has resources allocated to related activity including regulation, safety, quality and standards and will have to consider the extent to which the programme can also be supported through re-prioritising and/or deferring current activity.

However, discussion with key stakeholders during the preparation of this PID has also highlighted the additional requirement for a supplementary dedicated resource over the next 2/3 years at programme support level, and for professional staff within some of the Departmental directorates, to ensure the delivery of agreed objectives and to support the work of the Programme Board and working groups. This could potentially be provided through fixed-term secondments. It is therefore proposed that a business case for this resource is completed as soon as possible.

The Director of HRD (who currently has the lead role in regulation of professional staff) has indicated that the Directorate would be willing to host this project provided additional resources were forthcoming.

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9b Programme Board

A Northern Ireland Confidence in Care Programme Board has been established to oversee the whole Programme. The Board are accountable for the success of the programme and are responsible for approval of all major plans and authorisation of any deviation from those plans.

The Programme Board are responsible for confirming the completion of the Programme and will report progress to the Departmental Board, as depicted

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below ensuring that the Departmental Board is made aware of any issues of concern.

While it is normally preferable to have a single programme SRO in this instance this will be shared between the Chief Medical Officer and the Chief Nursing Officer, both of whom are also members of the Departmental Board

A Programme Director/manager, of suitable seniority, will be appointed for the day to day running of the programme and will have appropriate programme management support with access to legislative expertise. The role of the legislative advisor is to ensure that all the references to NI legislation quoted in the GB legislation are accurate and complete and are in accordance with the local NI policy requirements. The advisor is also required to provide associated advice throughout the process.

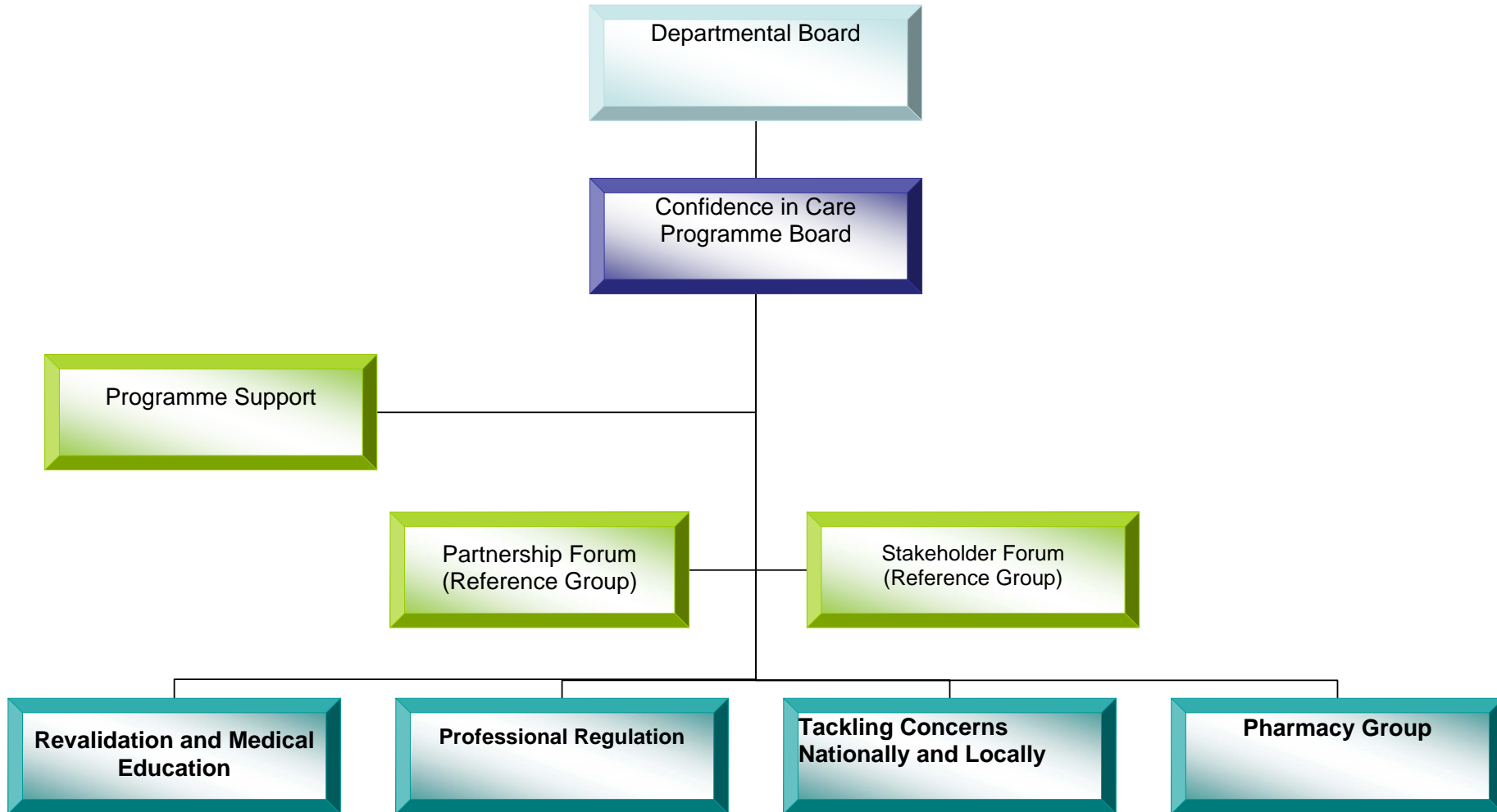
The Programme Board meet on a 6 weekly basis. Deputies are only acceptable with the agreement of the Programme SROs. At each meeting, the Programme Board among other things consider;

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- An updated Programme Plan
- A highlight report from each of the working groups detailing progress against agreed milestones in Project Plans, next steps and potential problems
- An updated Programme Risk Register
- Matters requiring approval and/or issues referred under escalation procedures

The Programme Board will report to the Departmental Board via quarterly highlight reports

9c “Confidence in care” Programme Structure



9d Stakeholder Forum

It is proposed that a forum will be established to facilitate key stakeholders, including representatives from professional bodies and academia to meet to discuss updates on progress and provide independent advice and input.

Forum Chair – Martin Bradley – Chief Nursing Officer, DHSSPS

9e Partnership Forum

Communication with staff side would be provided largely through the exiting partnership forum. The framework document on Partnership Arrangements for HSC states that the remit is:

- providing advice to the DHSSPS and the HPSS regarding partnership and employment issues
- supporting research and development in employment issues
- supporting and advising the project groups established to develop key themes of the HR Strategy and
- providing advice and support in the development of employment issues from the Workforce Planning Initiatives.

9g Working Groups

The Programme Board will be supported by four workstreams, each of which will have a lead person identified who will:

- report directly to or be a member of the Programme Board,
- ensure the appropriate project /administrative support is available for their team.
- be responsible for meeting agreed objectives and reporting to the Programme Board

Workstream and Chairs

Tackling Concerns Nationally and Locally – Paddy Woods

Medical / Non Medical Revalidation and Medical Education – David Bingham

Professional Regulation – Martin Bradley

Pharmacy Group – Norman Morrow

In order to co-ordinate the outputs of the workstreams it is proposed that the leads will meet on a monthly basis with the Programme Director, approximately 10 days before the Programme Board meeting, to discuss progress and highlight any issues to be addressed.

The complexity of the programme is reflected in the overall approach. The methodology describes a series of interlinked Projects. The Programme Board will consequently oversee and quality assures the contribution of the various work streams to the overall requirements.

9h Programme Board Membership

Name	Role	Organisation
Michael McBride	Chief Medical Officer Co chair (SRO)	DHSSPS
Martin Bradley	Chief Nursing Officer Co chair (SRO)	DHSSPS
Miriam McCarthy	Deputy Secretary	DHSSPS
Paddy Woods	Senior Medical Officer	DHSSPS
David Bingham	Director HR	DHSSPS
Donncha O'Carolan	Acting Chief Dental Officer	DHSSPS
Norman Morrow	Chief Pharmaceutical Officer	DHSSPS
Nuala McArdle	Principle Officer Allied	DHSSPS

	Health Professionals	
Maggie Reilly	Chief Officer	WHSSC
Joan Pedan	Co-Director Governance, Equality and Improving Working Lives, Belfast HSC Trust	Belfast Trust
Bernard Mitchell/ Levette Lamb	Programme Director	DHSSPS
Christine Jendoubi	Director Primary and Community Care	DHSSPS
David Galloway	Director of Secondary Care	
Paul Martin	Social Services Chief Inspector	DHSSPS
Carolyn Harper	Deputy Chief Medical Officer	DHSSPS
Jim Livingstone	Director of Safety , Quality and Standards	DHSSPS

9e Roles and responsibilities

Co Chairs (SROs)

The co-chairs are responsible for ensuring that the Programme meets its objectives and delivers its stated benefits. The co-chairs are ultimately accountable for the success of the programme and are responsible for enabling the organisation to exploit the new environment resulting from the programme, meeting the new business needs and delivering new capabilities.

Programme Manager/ Director

The Programme Manager/ Director has the authority to run the programme on a day – to day basis on behalf of the steering group within stipulated constraints with appropriate project management support. The Programme Director's main

responsibility is to ensure that the programme produces the required products to the required standard of quality within the specified constraints of time and cost.

9f Governance Arrangements

To promote effective governance of the Programme:

- The SRO / Project managers of each of the working groups will be tasked with ensuring that 6 weekly reports are prepared for the Programme Board.
- The Programme Board will implement a Communication Plan which ensures that there is effective communication with key stakeholders and between the component parts of the Programme. This will include a regular meeting of the Northern Ireland representatives on each of the working groups which will be chaired by the Programme Director.
- A template for Highlight Reports has been developed and issued to each of the project SRO/ project managers to ensure that they are consistent and fit for purpose
- The Programme Board will ensure escalation arrangements are in place so that mission-critical problems are drawn to the attention of the Departmental Board in good time.

10. Risk Assessment

The list below sets out the risks associated with the Programme. The actions taken and/or position with regard to each risk are detailed in **risk register**.

- Lack of robust programme management
- Risk of ineffective communication due to the complexity of the programme
- Lack of representative input into the DoH working groups
- Regional voice will not be heard
- Inappropriately resourced Programme Team
- Lack of control, with the pace of progress generated by DOH in England

11. Communication Plan

Effective Communication is a crucial component of this programme and a considerable challenge due to the dispersed nature of the staff affected including those in the independent, voluntary and community sector, the large number of stakeholders and the complexity of the Programme both nationally and locally. There will also need to be consideration given to the specific issues associated with locum and agency employees. Good communication will enable regular reporting of developments on implementation of the programme and enable stakeholders to feed their views, comments and concerns easily. **See Communication Strategy**

12. Programme Plan

TBC

Appendix 1

TRUST, ASSURANCE AND SAFETY –THE REGULATION OF HEALTH PROFESSIONALS IN THE 21ST CENTURY

1. Assuring independence: the governance and accountability of the professional regulators

This section sets out a series of measures to ensure the independence of the national professional regulators. In order to exercise their functions effectively and command the confidence of patients, the public and the professions, they need to be seen to be independent and impartial in their actions. To ensure that this is the case, the White Paper proposes that:

- the councils that regulate health professionals have, as a minimum, parity of membership between lay and professional members, to ensure that purely professional concerns are not thought to dominate their work;
- the Government will agree arrangements to ensure that all councils become more accountable to Parliament, presenting annual reports to the UK Parliament and, for those councils that regulate professionals whose regulation is a devolved matter, to the Devolved Assembly legislatures;
- to dispel the perception that councils are overly sympathetic to the professionals they regulate, council members will be independently appointed;
- to enable councils to focus more effectively on strategy and the oversight of their executives, they will become smaller and more-board like, with greater consistency of size and role across the professional regulatory bodies;
- Similar changes will be made to the Council for Healthcare Regulatory Excellence (CHRE), enabling it to take on a stronger and more independent role in providing expert advice on professional regulation;

- there will be no mergers, for the time being, of the professional regulatory bodies and the Government will review these arrangements in 2011; and the Government will work with the pharmacy profession to establish a General Pharmaceutical Council responsible for the regulation of pharmacists and pharmacy technicians, and the registration of pharmacy premises. The profession will need a strong and clear voice to assume the critical responsibility of undertaking a role akin to that played by a Royal College, supporting clinical excellence in the profession. A working party will be established to take forward detailed proposals. Its work will help inform future decisions about the regulation and leadership of pharmacy in Northern Ireland.

2. Revalidation: ensuring continuous fitness to practise

This section sets out new proposals to ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.

For doctors, the Government endorses the revalidation proposals set out in the Chief Medical Officer's report, Good doctors, safer patients. Medical revalidation will have two core components: relicensure and specialist recertification.

For relicensure, all doctors will have a licence to practise that enables them to remain on the medical register. This licence to practise will have to be renewed every five years. In order to bring objective assurance of continuing fitness to practise, the appraisal process will include 'summative' elements which confirm that a doctor has objectively met the standards expected. Specialist recertification will apply to all specialist doctors, including general practitioners, requiring them to demonstrate that they meet the standards that apply to their particular medical specialty. These standards will be set and assessed by the medical Royal Colleges and their specialist societies, and approved by the

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General Medical Council (GMC). The Department will discuss with stakeholders ways of ensuring that revalidation can be applied appropriately to all practising 71doctors, not just those who work in the NHS.

For the other health professionals, this White Paper sets out new arrangements to ensure that they also have the opportunity to demonstrate their continuing fitness to practise through appropriate revalidation arrangements. The Department will discuss with each profession and its regulator the most appropriate arrangements.

Professionals in England will fall broadly into one of three groups for revalidation:

- For employees of an approved body, for example nurses, dieticians or paramedics working in an NHS organisation or a licensed private or independent sector provider, evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators.
- For those, including self-employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists), the revalidation processes will be carried out under the supervision of either the NHS commissioning organisation or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory body, but in either case with appropriate collaboration between the two bodies.
- For all others, for example osteopaths, the relevant regulatory bodies will develop direct revalidation arrangements.

The responsibility for revalidation arrangements for staff directly employed by primary care contractors, for example practice nurses or dental hygienists, will be discussed with the relevant professions and regulators.

The appraisal process, which will be a central component of revalidation, should be both formative and summative, to ensure objectively that required standards are met. Within the English NHS, information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis. Scotland, Wales and Northern Ireland will consider how they wish to take this forward within their particular contexts.

3. Tackling concerns: the local role

For doctors and other relevant health professionals working in primary care, the Government will review the current Performers List arrangements to consider whether or not they are being used effectively. In particular, following the GMC's introduction of the GP register in April 2006, the Government will consider the regulatory burden of separate lists being held by each primary care trust (PCT).

For all doctors working in the UK, the Government will seek parliamentary approval to establish a UK network of GMC Affiliates at a regional level in England and at a national level in Scotland, Wales and Northern Ireland. In some larger regions with a large number of doctors, sub-regional arrangements may provide more effective engagement with local services. The Government will pilot these approaches at different levels of engagement in England prior to full-scale rollout. The Devolved Administrations will consider implementation of the Affiliates measures in the light of learning from these pilots.

Appointed by, and accountable to, the GMC, the Affiliates would lead and establish devolved GMC offices in England and work within existing structures in Scotland, Wales and Northern Ireland. In England, they would lead regional medical regulation support teams, including the strategic health authority (SHA) the director of public health, the SHA clinical governance lead, the National

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Clinical Assessment Service (NCAS), the Healthcare Commission (or its successor), the postgraduate dean and four lay GMC Affiliates.

Advised and assisted by the regional medical regulation support teams, the GMC Affiliates would provide support, advice and guidance to employers in managing concerns about doctors and would quality assure the processes for revalidation of doctors.

These changes mean that medical directors, and others in similar roles, will take on the organisational roles originally envisaged for GMC Affiliates in Good doctors, safer patients. In England, all practising doctors on the medical register will need to relate to a responsible officer approved by the GMC Affiliate. Where medical directors are in place, they will generally take on this role.

The Department will lead a project to establish more explicit competencies for the role of medical directors as well as measures to enhance their direct accountability to boards for actions relating to their new responsibilities and powers for regulation and revalidation. In England, all PCTs will be expected to have in place, at board level, a responsible officer.

Good doctors, safer patients also proposed a new measure, Recorded Concerns, for the local regulation of concerns about doctors' conduct or practice that will facilitate proportionate local responses to problems and allow patterns of misconduct or behaviour to be tracked over time and place. The Department will discuss with key stakeholders from across the UK how to frame detailed proposals on the practical implementation of the new system of GMC Affiliates and Recorded Concerns through a piloted approach in England, with the Devolved Administrations considering local arrangements in the light of learning from these pilots. The Department will invite stakeholders covering appropriate UK interests to participate.

In order to provide assurance of the quality of all health professionals who work as locums, the Department will consider, with stakeholders, the regulatory and other impacts of developing a more effective system of registration and inspection for agencies supplying health professionals.

4. Tackling concerns: the national role

This section sets out proposals to ensure public and professional confidence in the handling of cases in which a health professional's fitness to practise is called into question. To ensure greater fairness and openness in the handling of such cases, the White Paper includes the following proposals:

- in the adjudication of fitness to practise cases for all health professionals, panels should use the civil standard of proof, with its sliding scale, rather than the criminal standard;
- CHRE should have enhanced powers to scrutinise the regulators' handling of fitness to practise cases;
- CHRE should develop common protocols for local investigations across all the regulators, with guidance to employers on when such cases should be referred to the national regulator;
- the Department should work with the NCAS, the GMC and the General Dental Council to agree protocols to ensure that, in England, full use is made of the NCAS in its investigations; and
- the Department should work with the NCAS and with stakeholders to review the cost-effectiveness of extending its scope to other health professionals, as suggested by the Public Accounts Committee.

To ensure an integrated, affordable and cost-effective approach to the health of all health professionals, the Department will establish a wide-ranging and inclusive national advisory group to inform the development of a national strategy. Including UK stakeholders, the group will advise on measures to ensure appropriate prevention and early intervention for health professionals; the role of

health in revalidation arrangements; enabling easier and confidential uptake of services; the roles and responsibilities of employers, regulators, professionals themselves and others in ensuring the health of professionals; and more effective arrangements for the rehabilitation of health professionals whose actions have led to regulatory involvement.

For doctors, the Government agrees with Dame Janet Smith and with the CMO that the separation of investigation and prosecution from adjudication is essential to ensure complete public and professional confidence in the independence of the decisions made by the adjudicator. Working closely with the GMC, the Government will seek legislative agreement to establish an independent body to adjudicate on fitness to practise cases involving the medical profession. Doctors and the GMC will have a right of appeal against the decision of the independent body to the High Court or the Court of Session.

For all the other regulators, the Government will charge the new independent body with establishing a central list of people, vetted and approved for all adjudication panels, chosen by the Appointments Commission for their expertise and specifically trained to undertake these duties in a fair and impartial manner. Regulatory bodies will be able to draw on this list in order to conduct independent adjudication panels within their own organisations. Over time, and in the light of the experiences of fully independent adjudication for the medical profession, other regulators may wish to adopt the independent body to provide further assurance of independence to the public.

5. Education: the role of the regulatory bodies

The Government agrees that the non-medical professional regulatory bodies should continue to be responsible for the educational standards of the professionals they regulate.

The Government recognises the gains to be secured from single oversight of medical education, but believes that change should be introduced in such a way as to preserve the expertise and experience of the present organisations that undertake this role. The Government agrees with the proposal, set out in the GMC's response to consultation, for a three-board model covering undergraduate education, postgraduate education and continuing professional development. The Department will work with the GMC to establish an undergraduate board and a continuing professional development board in the GMC. The Postgraduate Medical Education and Training Board will continue as a separate legal entity, fulfilling the role of the postgraduate board within this three-board approach. Both organisations will continue to have a duty of cooperation.

The Department will ask UK professional regulatory bodies to work with NHS employers to develop arrangements for selective language testing for applicants to posts, where appropriate.

6. Information about health professional

This section sets out further proposals for the professional registers and the extension of the information held on them for patients, the public, employers and the professions.

Entry to the professional register depends ultimately on demonstrating fitness to practise by securing the educational qualifications and, in some cases, levels of competence, recognised by the relevant regulatory body. As 'The regulation of the non-medical healthcare professions' noted, however, the different regulatory bodies have similar, though not identical, requirements of people seeking new registration. The Government will ask CHRE to recommend a single standard definition of good character, working with the regulatory bodies, and encompassing wider work within Europe to promote information sharing on the good character of professionals who cross national borders.

The Government will also take forward the recommendation to ensure closer co-operation and co-ordination between regulators and employers when a health professional enters employment for the first time. The Department will ask CHRE to lead a programme of work with regulators and employers from across the UK to investigate the feasibility and practicability of these proposals, reporting to ministers by April 2008.

Good doctors, safer patients and 'The regulation of the non-medical healthcare professions' raised the issue of whether students and trainees should have closer relationships with their future regulators prior to qualification. The Government believes that each regulator should consider this issue on the basis of the risk presented to patients by trainees and students in particular professions. The Department will ask the regulators to report back with proposals by January 2008.

The Government agrees with the CMO's key proposals for changes to the medical register. The medical register should be the key national list of doctors entitled to practise in the UK. The Department will discuss with the GMC how the register can be further developed to become the single authoritative source of information on doctors, including disciplinary action by employers and alert notices. In reviewing such arrangements, the Department will ask the regulators what other changes could be made to provide better access to information for patients, the public and employers.

7. New roles and emerging professions

Some existing professionals who are not statutorily regulated have been in practice with patients for many years; practice that carries at least the same potential risk to members of the public who use their services as that of the statutorily regulated professions. The Government believes that these professionals should also be subject to a system of regulation that is proportionate to the risks and benefits entailed.

The Government is planning to introduce statutory regulation for applied psychologists, several groups of healthcare scientists, psychotherapists and counsellors and other psychological therapists. These are the priorities for the introduction of statutory regulation.

For emerging professions, the Department will establish a UK working party to develop criteria to determine which roles should eventually be statutorily regulated. The regulation of emerging and existing unregulated professions will be managed by the existing statutory regulatory bodies and the proposed new General Pharmaceutical Council. This will help to foster consistency where appropriate and the application of best regulatory practice across all regulated professions. With the exception of the new arrangements for the regulation of pharmacy, the Government will not establish any new statutory regulators.

The Government will consider areas in which regulatory practice and legislative provisions should be harmonised across the regulators so that they all have the most up-to-date and comprehensive duties and powers.

Where a health professional joins a new regulated profession from within an existing regulated profession, it might be possible for them to remain registered with their existing regulator, in a system of distributed regulation, to avoid costly dual regulation.

8. Implementation

The Government will consult with the Devolved Administrations, the regulators, the professions, employers and other key stakeholders on the development of a detailed implementation programme that encompasses both this White Paper and the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, Safeguarding Patients.

Many of the reforms set out in this White Paper will require primary legislation. Other measures need to be enabled by seeking parliamentary approval for secondary legislation. On specific matters where there is clear public, professional and parliamentary agreement on the need for change, the Department will consider with stakeholders whether it would be appropriate to seek Parliament's agreement in primary legislation to enable these issues to be addressed through secondary legislation. These legislative proposals will be developed in close consultation with the Devolved Administrations to ensure that they are appropriate to the whole of the UK.

The White Paper sets out the key principles for a lasting settlement for professional regulation, but putting those principles into practice will require the advice and participation of a wide range of stakeholders to ensure effective delivery. The Government will establish an inclusive national advisory group on professional regulation to advise the Department and the Devolved Administrations on the detailed implementation of the White Paper and the response to the Shipman Inquiry, and related inquiries.

Appendix 2

Comparison of White Paper recommendations against NISCC activity.

<p style="text-align: center;">White Paper Trust, Assurance & Safety</p> <p><u>Recommendations</u></p>	<p style="text-align: center;">NISCC</p>
<p>1. <u>Assuring Independence</u></p> <ul style="list-style-type: none"> - Parity of membership between lay and professional - Accountability to Parliament - Independent appointments - Smaller councils - Expert advice (CHRE) 	<p>Membership = 1/3 lay, 1/3 registrants, 1/3 stakeholders Current membership = 5 social workers/7 'other'</p> <ul style="list-style-type: none"> - NISCC accountable to NI Assembly through DHSSPS (Permanent Secretary = accountable officer) - members are publicly appointed - Council downsized from a possible 24 members + Chair to 12 members + Chair following a review in 2005. Remuneration for members introduced in October 2007. - no equivalent
<p>2. <u>Revalidation – fitness to practise</u></p> <ul style="list-style-type: none"> - Revalidation of professional registration - Re-licensure + specialist recertification 	<ul style="list-style-type: none"> - re-registration every 3 years - registrants expected to undertake 5 days post-registration training and leaving per year (15 days every 3 years) to be eligible for re-registration. <p>Employers endorse registrants' application for re-registration PSS Development and Training Strategy 2006 – 2016 – strategic target of a phased introduction of linking re-registrations with accredited training/qualifications by 2016. Opportunity to review employer involvement in re-registration</p>

<p>3. <u>Tackling concerns – the local role</u></p> <ul style="list-style-type: none"> - Sub-regional arrangements for more effective engagement with local services - GMC affiliates - role of Medical Directors - Record concerns to track patterns of concern - More effective registration and inspection and inspection for agencies supplying health professionals 	<ul style="list-style-type: none"> - devolved Social Care Councils in 4 jurisdictions - professional accountability arrangements for social work clearly set out in new arrangements under RPA with Director of Social Work/Services in new Trusts - all reported concerns are recorded and retained by NISCC even where individual is not yet registered - RQIA → extension of regulation of social care services
<p>4. <u>Tackling concerns – the national role</u></p> <ul style="list-style-type: none"> - Civil standard of proof - External scrutiny - CHRE - National advisory group – health of health professionals - Separation of investigation and prosecution from adjudication - Regulatory bodies work with NHS employers to develop arrangements for selective language testing for applicants to 	<ul style="list-style-type: none"> - civil standard of proof - registrant can challenge process (Judicial Review) or outcome (Care Tribunal) - Same requirement re health. Enshrined in registration and where it is root cause of misconduct. Would be interested in national strategy – early intervention. (NB: current challenge reported by Disability Rights Commission) - Conduct committees are independent from Council members and staff. They are trained and supported by NISCC staff. - EU Directive 2005/36 prevents NISCC from administering or taking into account language proficiency of visiting EEA professionals for

<p>posts</p>	<p>registration purposes. Same standards applied to overseas nationals. Workers from outside UK are an increasing reality in the social care workforce in NI and language proficiency can be an issue. NISCC could work with employers to develop arrangements for selective language testing with employers but cannot administer or take this into account for registration purposes</p>
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<p>5. <u>Education – the role of the regulatory bodies</u></p> <ul style="list-style-type: none"> - Regulatory bodies responsible for educational standards of the professionals they regulate 	<ul style="list-style-type: none"> - regulatory body for social work training (qualifying and post-qualifying) - contribute to development of national occupational standards which underpin NVQs → recognised qualification for social care workers
<p>6. <u>Information about health professionals</u></p> <ul style="list-style-type: none"> - Single standard definition of good character - Information-sharing on good character of professionals who cross national borders - Closer co-operation and co ordination between regulation and employers when a health professional enters employment for the first time - Closer relationship of students and trainees with future regulator 	<ul style="list-style-type: none"> - Interested in consistent approaches across health and social care given integrated structures in NI. - EU Directive 2005/36 will establish a database of regulatory bodies in other EU countries which will facilitate information-sharing. No similar arrangements for countries outside EU. - Assessed Year in Employment (AYE) – newly qualified social workers are registered for one year in first instance and employer must confirm successful completion of AYE which is based on consolidation of graduate training. - requirement for social work students to be registered with NISCC as a condition of enrolment on an approved social work Degree course

Appendix 3

PART I SOCIAL CARE WORKERS

Preliminary

The Northern Ireland Social Care Council

1.—(1) There shall be a body corporate to be known as the Northern Ireland Social Care Council (referred to in this Part as “the Council”) which shall have the functions conferred on it by or under this Part or any other statutory provision.

(2) It shall be the duty of the Council to promote—

- (a) high standards of conduct and practice among social care workers; and
- (b) high standards in their training.

(3) The Council shall, in the exercise of its functions, act—

- (a) in accordance with any directions given to it by the Department; and
- (b) under the general guidance of the Department.

(4) Schedule 1 shall have effect with respect to the Council.

“Social care worker”, etc.

2.—(1) This section has effect for the purposes of this Part.

(2) “Social care worker” means a person (other than a person excepted by regulations) who—

- (a) engages in relevant social work (referred to in this Part as a “social worker”);
- (b) is employed at—
 - (i) a children’s home;
 - (ii) a residential care home;
 - (iii) a nursing home;
 - (iv) a day care setting;
 - (v) a residential family centre;

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(c) manages an establishment of a description mentioned in paragraph (b); or

(d) is supplied by a domiciliary care agency to provide personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.

(3) Regulations may provide that persons of any of the following descriptions shall be treated as social care workers—

(a) a person engaged in work for the purposes of the personal social services functions of a Health and Social Services Board or HSS trust;

(b) a person engaged in the provision of personal care for any person;

(c) a person who manages, or is employed in, an undertaking which consists of or includes supplying, or providing services for the purpose of supplying, persons to provide personal care;

(d) a person engaged in the provision of services which are similar to services which may or must be provided by Health and Social Services Boards or HSS trusts in the exercise of their personal social services functions;

(e) a person employed in connection with the discharge of functions of the Department under Article 149 of the Children (Northern Ireland) Order 1995 (NI 2) (inspection of children's homes etc.);

(f) a person participating in a course approved by the Council under section 10 for persons wishing to become social workers.

(4) "Relevant social work" means social work which is required in connection with any health, education, probation or personal social services provided by any person.

Appendix 4

Regulation of Healthcare Professional – Implications for Northern Ireland

Independent adjudication: It is intended to provide for an independent adjudicator who will hear fitness to practise cases of professionals within the scope of the healthcare regulatory bodies.

Lay majorities: It is proposed to amend the Health Act 1999 to permit subordinate legislation to provide for a Council of a healthcare regulatory body to have a majority of lay members.

Standard of Proof: It is proposed to ensure that healthcare regulatory bodies adopt a civil standard of proof in determining allegations of lack of fitness to practise.

Responsible Officers: The introduction of provisions that will require healthcare organisations to appoint an officer known as a “Responsible Officer. The Responsible Officer would have duties to safeguard patients by identifying and handling issues of poor performance by doctors, liaising with the General Medical Council on possible fitness to practise cases and making recommendations on the re licensing of doctors.

Council for Healthcare Regulatory Excellence (CHRE): It is proposed to amend the constitution and functions of CHRE, in particular it is proposed that the appointment of non-executive members of the Council will be made by the Privy Council with the provision that they must ensure that at least one member is appointed from each of England, Wales, Scotland and Northern Ireland and lives or works wholly or mainly in the country concerned. Currently the appointment of a Northern Ireland representative is made by DHSSPS.

Pharmacy: The Pharmaceutical profession is enjoined in the wider regulatory reform of the health professions. At the same time there are matters specific to the profession which have a unique bearing on the Northern Ireland context. In Great Britain the pharmaceutical profession is regulated by the Royal Pharmaceutical Society of Great Britain (RPSGB) while here it is by the Pharmaceutical Society of Northern Ireland (PSNI). Both bodies have both

regulatory and professional leadership functions. The decision has been made in Great Britain to separate these functions in favour of a General Pharmaceutical Council for regulation and a College-like body for professional leadership.

The Minister for Health Social Services and Public Safety in Northern Ireland has indicated his support for this principle and to the establishment of a General Pharmaceutical Council covering the profession throughout the UK. This would harmonise arrangements not only across the profession itself but with other health professions who are already regulated on a UK-wide basis.

Appendix 5

GROUP 1: MEDICAL EDUCATION AND REVALIDATION: A DISCUSSION PAPER

The White Paper, Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (February 2007) set out the following recommendations:

- Medical revalidation will have two components: relicensure and specialist recertification. All doctors wishing to practise in the UK will require a licence.
- The Department of Health England will consult with the GMC, the profession, the medical royal colleges, patient groups, NCAS and the Devolved Administrations, and develop proposals to commission and pilot appropriate national tools for multi-source (360 degree) feedback to support this process.
- The Department will discuss with stakeholders the most effective means for the introduction of an appraisal process with summative components. The quality of the process will be regularly assured by the GMC. The appraisal arrangements will need to take account of the large number of doctors who work outside the NHS/HSC as well as in the NHS/ HSC.
- There are some non-medical professional staff, such as clinical scientists, who undertake higher specialist training and practise for most of their careers at a specialist's autonomous level. DH will work with the Devolved Administrations to establish a short term working party to consider how regulation and revalidation should reflect this.
- The Government agrees with the proposal for a three-board model covering undergraduate education, postgraduate education and continuing professional development.

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The working group established to address this area will be asked to consider these proposals and to make recommendations on the timely, effective and affordable introduction of a revalidation system comprising relicensure and re-certification of doctors. The group will also be asked to consider the impact of the introduction of such a system on medical education, training and continuing professional development.

GROUP 2: NON-MEDICAL REVALIDATION: A DISCUSSION PAPER

The White Paper – Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century - set out proposals to ensure that all the statutorily regulated health professionals have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.

The White Paper endorsed the recommendations of the Foster Review that the regulatory body for each non-medical profession should develop the standards that the registrant will need to meet periodically to maintain their registration. It is noted that it will be important that those standards and arrangements for assessment are proportionate to the risk that each profession may pose to the public.

The working group addressing this area will be asked to consider and make recommendation on:

- A clear definition of revalidation across medical and non-medical working groups to ensure commonality of understanding and language;
- The scope, structure and processes for revalidation for all statutorily regulated non-medical health professionals, paying particular attention to how these interact with existing clinical governance/risk systems;
- What revalidation will mean in terms of post-registration (advanced or higher level practice);
- A process for establishing common standards across the regulators and clarifying where this is not appropriate;

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- The use of information systems to collect data that might be used for appraisal and revalidation, and how to overcome problems around confidentiality and data protection issues;
- Effective appraisal processes (both formative and summative) and clarifying the role of the Knowledge and Skills Framework in revalidation;
- Revalidation and appraisal processes for health professionals working in non-NHS/HSC sectors, e.g. research, teaching and private sector health providers;
- Models for Continuing Professional Development and demonstrating how they fit in with formative and summative processes for appraisal;
- Models for piloting recommendations made by the group and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems;
- The consequences of failed revalidation in terms of systems and support and how this would work with fitness to practise procedures;
- The timetable for the introduction of new processes within the five-year window.

It is proposed that, by the end of 2008, this group, working jointly with the medical revalidation working group, will develop:

- Generic standards to support summative appraisal;

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- Standards for specialist/advanced practice;
- Methods of testing against the agreed standards;
- Pilot studies to inform development of a system of revalidation (reflecting differing standards of risk);
- An effective appraisal and revalidation system for all non-medical health professionals, which meets the requirements and standards set out in the White Paper, is acceptable to stakeholders, and practical and affordable to the NHS/HSC and others;
- A remediation strategy for those not meeting the relevant standards; and
- Guidance on the role of the employer and individual in the revalidation process.

GROUP 3: TACKLING CONCERNS LOCALLY: A DISCUSSION PAPER

A series of high-profile cases in the late 1990s drew attention to the need for better systems to identify and address concerns about individual professional conduct and competence. Subsequently, the Donaldson and Foster Reviews highlighted the need for clarity about the respective responsibilities of local employers, local commissioners and regulators and for close co-operation between them.

The key proposals for addressing this area, as set out in the White Paper are:

- Better signposting of the means for lodging complaints and concerns and better handling in healthcare organisations;
- Improving skills and capacity to investigate complaints and concerns, including guidance on the thresholds at which issues should be referred on to the professional regulator
- The better use of quality indicators to help identify potential poor performance, including (for GPs) “practice profiling” and the use of information from death certification;
- The development of guidance on managing and where appropriate sharing information held by individual employers or PCTs
- The development of GMC register as a central authoritative source of information on doctors, including disciplinary action by employers and alert notices, and the potential equivalent arrangements for other professions;

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- A review of the Performers List arrangements in England; and
- The introduction of a network of “GMC Affiliates” linked to “responsible officers” in individual healthcare organisations, to improve the liaison between local management and the national GMC.

The group established to address this area will be asked to consider:

- Potential development and piloting of a UK network of GMC Affiliates initially at a regional level in England and subsequently at a national level in Scotland, Wales and N Ireland;
- To consider the development of the “Responsible Officer” concept and establish more explicit competencies and accountability for the role of medical directors in England;
- To inform the review of the Performers List in England;
- To inform the review and development of systems for collecting and using information on health professionals for complaints, investigations and disciplinary measures;
- To review and up-date current guidance on clinical governance;
- To inform the development of improved arrangements for death certification;
- To ensure equality and diversity issues are fully considered in all work streams; and

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- To ensure that recommendations are sensitive to the relevant differences in the healthcare systems of England, Scotland, Wales and Northern Ireland.
- This group will be required to liaise with other working groups.

GROUP 4: TACKLING CONCERNS NATIONALLY: A DISCUSSION PAPER

The Donaldson and Foster Reviews highlighted the need to develop greater confidence in the way professional bodies deal with concerns about individual professional conduct or competence. The way in which professions and their regulators respond is often subject to scrutiny from patients, the public in general, and the media. Confidence in the handling of fitness to practise cases is therefore fundamental to sustaining confidence in the system of professional regulation as a whole.

To address this, the White Paper recommended:

- The civil standard of proof, with its sliding scale, should be the common standard of proof for all the regulatory bodies in fitness to practise proceedings;
- Consideration of whether a common memorandum of understanding between the healthcare professional regulators and the Healthcare Commission and ombudsmen would be desirable and whether this should apply across the UK;
- For doctors, the separation of investigation and presentation of cases from adjudication by establishing an independent body to adjudicate on fitness to practise cases involving the medical profession;
- For all other regulators, the new independent body should establish a central list of vetted and approved potential panellists for all adjudication panels, chosen by the Appointments Commission for regulatory bodies to draw on in order to conduct independent adjudication panels within their own organisations;

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- The development by the Council for Healthcare Regulatory Excellence (CHRE) of a single standard definition of good character;
- The medical register should be the key national list of doctors entitled to practise in the UK; and
- The Register should be further developed to become the single authoritative source of information on doctors, including disciplinary action by employers and alert notices.

It is proposed that the group established to address this will be required to:

- Oversee the creation of the new Independent Adjudication Body, to adjudicate fitness to practise cases referred to it and to maintain a central list of trained panellists for all fitness to practise cases;
- Develop advice and options on achieving harmonisation of Fitness to Practise systems, including reviewing of closed cases at investigation stage and decisions not to proceed to adjudication; this will include a locus on the CHRE project for a single definition on good character;
- Develop advice and options on what information might be best to record on a regulator's register and the tiers of disclosure appropriate for employers and the public;
- Review the existing Memoranda of Understanding between regulators and other organisations with a view to effective protection of the public; and

- Ensure equity and diversity issues are fully considered in all work streams.

GROUP 5: HEALTH FOR HEALTH PROFESSIONALS: A DISCUSSION PAPER

The increasing complexity of modern clinical practice has placed greater pressure on health professionals. In recognition of this, there needs to be a greater emphasis on remediation, rehabilitation and support for those health professionals who struggle to cope.

The group established to address this will be required to:

- Inform the development of an integrated national health strategy covering all health professionals;
- Oversee the development of a service specification of a pilot service for practitioners with mental health or addiction problems;
- Ensure recommendations from the BMA's "Doctors for Doctors" pilot are considered;
- Ensure the recommendations from the forthcoming report "Mental Health and Illness in Doctors" by Louis Appleby are considered as part of the work programme;
- Ensure this work interfaces with the fitness to practise procedure work stream; and
- Ensure work on relevant policy areas is reflected in the overall strategy.

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The work of this group will reflect all professional working contexts, including the independent sector, students and trainees and will support a risk-based approach that seeks to provide support and rehabilitation where possible and appropriate.

GROUP 6: EXTENDING PROFESSIONAL REGULATION: A DISCUSSION PAPER

Although a large number of professionals are already regulated it is important that the scope of statutory regulation is kept under review. Some existing professionals who are not statutorily regulated have been in practice with patients for many years, carrying at least the same potential risk to people who use their services as that of the professions currently regulated.

The group established to take this forward will be required to:

Develop criteria against which all roles in the UK will be judged to determine which should be regulated. The criteria should take account of:

- The wide variety of existing and emerging professions that are either seeking statutory regulation or, on the basis of risk, may require regulation;
- The work carried out by the National Governance Group that now oversees the development of new roles in England and any similar groups in the Devolved Administrations;
- Existing evidence supporting the demand for emerging roles within the health services across the UK;
- The available options of stand-alone statutory regulation; post-registration specialists qualifications recorded on the register that are to agreed common standards regardless of original primary qualifications; no statutory regulation, but with the option for voluntary registration.

The group will also be required to make recommendations, based on these criteria, on which groups should be considered for statutory regulation.

GROUP 7: ENHANCING CONFIDENCE IN PROFESSIONAL REGULATION: A DISCUSSION PAPER

Patients, the public and health professions need to be able to take it for granted that the Councils overseeing the administration of the policies and procedures of the regulatory bodies carry out their functions without due regard to any one particular interest, pressure or influence. Doubts based on perceived partiality have threatened to undermine this trust in a number of the regulators over the years.

To regain confidence, all stakeholders need to be assured of the independence of Councils. To achieve this it is recommended that professionals do not form a majority in the membership of the Councils, and that all members, both lay and professional, are appointed rather than elected.

The White Paper set out a number of recommendations to achieve these aims:

- The reconstitution of councils with parity of membership as a minimum;
- For the regulators that adopt parity rather than lay majorities, the putting in place of alternative packages of measures to demonstrate their impartiality;
- The appointment of all members of all Councils independently by the Appointments Commission against clearly specified criteria and competencies; and
- Councils moving to a more consistent and smaller size that enables them to function more effectively as Boards for their organisations, with a

statutory duty to ensure that the interests of all its stakeholders are considered in its deliberations.

The group established to take this forward will be required to make recommendations on:

- The strategic role of councils;
- Measures to demonstrate to the public, patients and parliament the councils' commitment to conducting their responsibilities in a manner that commands public confidence;
- How to ensure that the interests of all stakeholders are considered in council deliberations;
- The size and composition of the councils;
- The role of the council committees;
- Job and person specifications for council members; and
- Ensuring equity and diversity issues are fully considered in all work stream