



**Implementing the White Paper  
*Trust, Assurance and Safety:*  
Enhancing confidence in  
healthcare professional regulators**

*Final Report*

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# Department of Health

## Response to the report of the White Paper Working Group: Enhancing Confidence in Healthcare professional Regulation

Chaired by Niall Dickson

In May 2007, Lord Hunt asked Niall Dickson, Chief Executive of the Kings Fund, to chair one of the seven working groups to take forward key recommendations in the White Paper *Trust, Assurance and Safety*. This group was asked to examine those aspects of the White Paper concerned with enhancing public confidence in the regulators of healthcare professionals. The report of the group, written by Niall Dickson, is published on this website.

A number of recommendations in the report identify actions for regulators and other independent bodies, rather than for the Department of Health to implement. We welcome these recommendations and would encourage those concerned to consider how best to implement them. For example, recommendations 2, 3, 26 to 28 and 31 develop the concept in the White Paper that Councils should be strategic and should be properly equipped to achieve this. In addition, recommendations 8-17 set out a series of proposals for regulators to engage with and respond to the concerns of stakeholders and for the enhancement of the understanding of professional regulation. These proposals fit with our desire to ensure that the councils of regulatory bodies engage with, and take into consideration the interests of all stakeholders. Also, recommendations 33 and 36 specifically cover issues of diversity and equality.

A number of the recommendations are already informing the development of Section 60 Orders, and are being taken account of as part of the consultation processes – for example recommendations 6, 23 and 24. Other recommendations, for example recommendation 4, will be taken into account when drawing up future Section 60 Orders and other secondary legislation.

We welcome recommendations 1 and 5 concerning the publication of key performance indicators by the Regulators and the role of the Council for Healthcare Regulatory Excellence (CHRE) in reporting on the performance of regulators. It would be helpful for CHRE and the regulators to agree a standard set of indicators that will apply to all regulators. If appropriate, additional regulator specific indicators could also be agreed.

Recommendation 7 suggests that Parliament should consider establishing a joint committee of both houses to oversee professional regulators. It is, of course, up to Parliament to decide how it is to exercise its oversight, but Ministers will discuss with parliamentary colleagues how best such oversight might be achieved. **Ministers in devolved administrations will also want to consider the recommendation as it relates to devolved matters.**

The second part of recommendation 17 relates to standards of conduct for students. We welcome this proposal in principle but its implementation is a matter for education providers.

We welcome recommendations 18, 19, 32, 34 and 35, which cover the membership of Councils and appointments. These recommendations take forward the ideas in the White Paper. We will draw these to the attention of the Appointments Commission.

Recommendations 20 and 21 propose a limit on the number of terms of office a council member can serve and recommend that councils should achieve regular turnover so that there is some level of stability and continuity. We accept the logic of these recommendations and note that some councils already operate a rotational model. We also accept the need for a limit on the number of terms that a member can serve. We will discuss with regulators the details of recommendations 20 and 21, with a view to these recommendations being reflected in draft secondary legislation.

We accept recommendation 22 that councils should aim for between 9 and 15 members. We also accept that some councils may not be able to achieve this immediately, particularly where they are currently much larger than the range suggested in this recommendation. We will need to plan with the regulators how quickly they can move to the new, smaller, size and consider this further in the review planned for 2011.

Recommendation 25 encourages all regulators seriously to consider joining the independent adjudicator (to be called OHPA – the Office of the Health Professions Adjudicator) before 2011. Although we welcome the support for the move towards independent adjudication, we do not believe that this will be possible for all regulators before 2011. The adjudicator will first need to take on the role in respect of doctors and those professions regulated by the General Optical Council and we will need to evaluate its work, along with Ministers from devolved administrations as appropriate, before considering extending its remit to other professions.

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Recommendation 29 suggests a “halfway house” between directly appointed chairs and those elected from amongst the appointed members. The White Paper recommended that the question of moving to appointed chairs should be reviewed in 2011. We will therefore leave the decision on this issue (which also relates to recommendation 30) to individual regulators and consider the proposal further as part of the review planned for 2011.

Finally, recommendations 37, 38 and 39 refer specifically to the work and membership of the Regulatory Bodies across the four countries of the UK. Recommendation 37 is for the regulators and we will discuss recommendation 38 further with the Devolved Administrations. We agree with the principle behind recommendation 39. However, we also recognise that there needs to be a way of ensuring that regulatory body councils are aware of and responsive to the differences which are emerging between the provision of healthcare in England, Northern Ireland, Scotland and Wales. In order to reflect the realities of devolution, we are proposing in the two Section 60 Orders that were published for consultation in November and December 2007 that the Councils of regulators should have at least one person who lives or works wholly or mainly in each of the four countries.

The Department of Health wishes to express its gratitude for the work that Niall Dickson and the members of the working group have undertaken and for the thorough and professional approach that has been taken to considering this complex range of issues. It will now be for the UK Government, the devolved administrations and regulators to take these recommendations forward.

**Implementing the White Paper *Trust, Assurance and Safety*.  
Enhancing confidence in healthcare professional regulators**

# **Implementing the White Paper *Trust, Assurance and Safety*:**

Enhancing confidence in healthcare professional regulators Final Report

**Implementing the White Paper *Trust, Assurance and Safety*.  
Enhancing confidence in healthcare professional regulators**

**Final Report**

**Niall Dickson**

**November 2007**

# Implementing the White Paper *Trust, Assurance and Safety*. Enhancing confidence in healthcare professional regulators

## 1. Terms of reference

**1.1** The terms of reference for this working group were to consider the recommendations in *Trust, Assurance and Safety* that will enhance public confidence in the healthcare professional regulators. In particular, to consider and 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
- ensuring equality and diversity issues are fully considered in all workstreams.

**1.2** During the course of preparing this report I met individually with each of the current healthcare professional regulators, as well as separately with parliamentarians and representatives from professional bodies. I also received written submissions from a variety of organisations involved with professional regulation. The working group which I chaired provided representation from key organisations in this area (see Appendix 2) and met on three occasions to discuss the issues in this report.

**1.3** I have sought to take account of the views expressed and indicated where consensus was reached, however the recommendations are mine based on the evidence I have heard.

## 2. Strategic role of councils

**2.1** The purpose of the healthcare professional regulators is established by Parliament with the single overriding objective being to protect the public by the setting of appropriate standards to which professionals are expected to adhere. Regulators should be autonomous bodies independent of the government but accountable to Parliament. The criteria to determine how well a council is working and whether it is commanding public confidence need to be defined - **each regulator should publish a set of key performance indicators after discussion with the Council for Healthcare Regulatory Excellence (CHRE).**

**2.2** The White Paper indicates that each regulatory body should have a smaller, more board-like council whose members are appointed rather than elected in order to fulfil more effectively their strategic role. **The role of a council should be to set the direction of the organisation in line with its mission and purpose. It should ensure systems are in place to enable it to monitor performance and to hold the executive to account. It should also ensure probity. Some regulators already have established schemes of delegation to achieve this, and it is recommended that this should apply to all regulators.**

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**2.3** The working group commissioned CHRE to carry out a short piece of work to identify best practice for effective boards from other sectors. A copy of that report is attached (Appendix 3). The CHRE paper, considering developments in corporate governance, such as the Cadbury Report (1992)<sup>1</sup> and Sarbanes-Oxley Act from the US<sup>2</sup>, highlighted 12 key principles that should underpin the work of an effective council. **The working group felt that an amended version of these principles reflecting the particular role played by councils of professional regulators would be useful and should be adopted by every regulator. (Table 1)**

**Table 1**

*Principles that should underpin the work of a council of a professional regulator:*

1. The council should uphold the purpose of the organisation as established by Parliament, determine its values and keep both its purpose and its values in mind at all times, with mechanisms in place for annual review.
2. The council should be forward and outward looking, focussing on the future, assessing the environment, engaging with the outside world, and setting strategy
3. The council should determine the desired outcomes and outputs of the organisation in support of its purpose and values
4. For each of its desired outcomes the council should decide the level of detail to which it wishes to set the organisation's policy - any greater level of detail of policy formulation should then be a matter for the determination of the chief executive and staff
5. The means by which the outcomes and outputs of the organisation are achieved should be a matter for the chief executive and staff; the board should not distract itself with the operational matters
6. The chief executive should be accountable to the council for the achievement of the organisation's outcomes and outputs
7. In assessing the extent to which the outcomes have been achieved, the council must have a framework of pre-determined criteria against which performance is reported both internally and externally.
8. The council should engage with its key interest groups including patients, the public, registrants, employers, educators and the devolved administrations, and be confident that it understands their views and priorities
9. The membership of the council should have the capacity and skill to understand the priorities of each of these key constituents
10. Information received and considered by the council should support one of three goals – to allow informed decision making, to fulfil control and monitoring processes or to enable the council to co-operate with CHRE and to be accountable to Parliament
11. The council must govern itself effectively, with clear role descriptions for itself, its chair, and its members, with agreed methods of working and self-discipline to ensure that time is used efficiently
12. The council must ensure that issues of equality and diversity are considered as

<sup>1</sup>Committee on the Financial Aspects of Corporate Governance (1992). *Report of the Committee on the Financial Aspects of Corporate Governance (The Cadbury Report)*. London: Gee Publishing.

<sup>2</sup> Public Company Accounting Reform and Investor Protection Act 2002. London: HMSO.

### **3. Measures to command public confidence**

**3.1** Several organisations pointed out that it would be wrong to assume that confidence levels among the public, or indeed professionals, are low. For example, polling carried out by the General Medical Council indicates that public confidence remains high<sup>3</sup>. At the same time, there was widespread acceptance that trust and confidence cannot be taken for granted and that changes were needed to ensure that confidence was retained and reinforced.

**3.2** The White Paper sets out a variety of mechanisms by which the regulators might command public confidence, including the appointment rather than election of members, parity (as a minimum) of lay and professional members and smaller councils. It also states that the Government will agree arrangements to ensure that all councils become more accountable to Parliament in order to enhance public confidence.

**3.3** There is widespread support for the idea that regulatory bodies should be accountable to Parliament (and in relation to some groups to the Scottish Parliament) but there is a complete lack of clarity about what this should mean in practice. The current arrangements are profoundly unsatisfactory with accountability more apparent than real.

**3.4** Although most of the regulatory bodies must lodge their annual reports with the Privy Council, this was regarded by many as nothing more than a 'post box' to the Department of Health. They argued that this cast doubt on the 'independent' nature of regulation and, as a result, were keen that in future real accountability should be to Parliament rather than to government.

**3.5** It should also be noted that some chief executives of regulatory bodies, in their role as registrars, are already directly accountable to Parliament for maintaining the register of practitioners, but this is not true of all the regulators. **In drawing up new arrangements, the Government should consider bringing together the accountability for the register with that of the regulatory body as a whole for those regulators to whom this does not already apply.**

**3.6** If accountability to Parliament is to be made real there must be a mechanism by which parliamentarians can scrutinise the work of the regulators. As things stand there is no such mechanism in place.

**3.7** The first requirement is that some form of external assessment of the work of the regulator would have to be prepared to enable parliamentary scrutiny to have any value. The Health and Social Care Bill<sup>4</sup> states that CHRE 'must prepare a report

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<sup>3</sup> GfK NOP Social Research. (2007) *Annual Tracking Survey (April – May 2006): A research report for the General Medical Council*. London

<sup>4</sup> *Health and Social Care Bill*. HC Bill (2007-2008) 9 clause 106

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on the exercise of its functions during each financial year. The report must state (a) how the Council, in exercising its functions, has promoted the health, safety and well-being of patients and other members of the public, and (b) how far, in the opinion of the Council, each regulatory body has complied with any duty imposed on it to promote the health, safety and well-being of such persons.' **Given that CHRE will be required to carry out these comprehensive annual performance reviews each year, it is recommended that it should provide the UK Parliament and where appropriate the Scottish Parliament, with an assessment of the performance of each regulator that in addition to looking back at the year past would also consider future plans. In addition, the regulator itself would have a duty to submit its strategic plan and annual report to the UK or Scottish Parliament.**

**3.8** The second requirement is that the Parliaments would need to have a means of considering this information, questioning CHRE and the regulators, and if appropriate, representatives of other key constituencies affected by the regulatory process. **One way of achieving this for the UK Parliament would be to establish a standing committee of both Houses to oversee professional regulators in health.** A similar concept to this was suggested in an amendment tabled in the 2002 House of Lords debate on the National Health Service Reform and Health Care Professions Bill, although in that instance the committee was intended as an alternative to CHRE<sup>5</sup>.

**3.9** Such a committee would hold evidence sessions each year during which individual regulators could be questioned on their annual report, strategic plan and CHRE assessment. CHRE would also be able to provide evidence on its assessment of each of the regulators. Under normal circumstances it would not be necessary for the committee to produce a report each year on every regulator - a letter in the public domain from the chairman of the committee to the chair of the regulatory body would usually be sufficient to set out the committee's conclusions. However, this would not preclude a more in depth report should the committee feel that was appropriate. A similar mechanism might be considered by the Scottish Parliament in those areas where professional regulation is a devolved matter.

**3.10** A number of regulators were concerned that they should not be subject to further scrutiny by the National Audit Office on the grounds, first, that they were already subject to external auditors and the CHRE performance reviews and, second, that while they were public bodies they did not use public funds.

**3.11** This argument has considerable force, and no-one would wish to subject the professional regulators to an unnecessary regulatory burden. However, there is a difference between a straightforward financial audit and assessing whether these organisations provide 'value for money'. Given that it is registrants who pay the fees and given the move away from elected councils, there is a stronger need than ever not only to ensure that regulators do exercise their duties in a cost-efficient manner,

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<sup>5</sup> *Hansard (House of Lords Debates)* (2001-02) 11 April 2002 col 646

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but also that they are seen to do so by those who have to pay. Although not all regulators accept this argument, some mechanism to ensure feedback to registrants does appear justified.

**3.12 It is therefore recommended that one of the criteria for the CHRE performance review is to assess whether the regulator is operating efficiently. Regulators should be required to make a report available each year to every registrant that includes a copy of the CHRE assessment on their performance.**

**3.13** It is also worth noting that some regulators are registered charities and, as such, are required to submit reports to the Charity Commission setting out how their money is spent and how resources have been used. This is a useful check but should not be regarded as a substitute for the system of accountability to the Parliaments described above.

#### **4. Engaging key constituencies**

**4.1** The purpose of every healthcare professional regulator is to protect the public, and they must all command the confidence of the public in order to achieve this. In addition, if they are to be effective, the regulatory bodies must command the confidence of other key groups who are involved with, or affected by, professional practice. In particular, each regulator should be paying close regard to the needs of registrants, employers and educators. At the same time it is vital that the regulatory bodies should be able to operate independently at all times in the interest of the public, informed by expert opinion, but never as a result of pressure from any particular interest or group. As the White Paper makes clear 'This will ensure that the regulators are not only independent in their actions, but, just as critically, that they are seen to be independent in their actions'<sup>6</sup>.

**4.2** As mentioned in other sections of this report, it would be a mistake to be too prescriptive about the precise ways by which regulatory bodies should engage with and secure the confidence of different groups. They will use a variety of formal and informal means to ensure good communication, engage, listen, consult and work alongside each group individually or collectively. Nevertheless, it may be helpful to set out the principles that should lie behind this work as well as highlighting examples of good practice.

- **Patients and public**

**4.3** For most patients and for the vast majority of the general public, professional regulation is not a matter of immediate interest. Most of us wish to be treated well by a competent practitioner and assume that there will be checks in place to ensure that there are good standards of conduct and practice. Often interest in the system of regulation only comes about when something is perceived to have gone wrong. Patient and public engagement therefore is particularly challenging in this area and formal structures are needed to demonstrate that it is being done effectively.

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<sup>6</sup> Department of Health (2007). *Trust, Assurance and Safety*. London: Department of Health

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**4.4** There are a number of different ways in which regulators need to engage with patients and the wider public. First, there is an obligation to ensure that the regulator understands the expectations of the public and is able to assure the public that it is carrying out its function effectively. Second, there is a related duty to ensure that all patients having contact with registrants are aware of the existence and purpose of the regulator and know how to make contact with the regulator should they wish to do so. In the case of employed registrants this may be achieved by the employer as part of their complaints procedures. Third, regulators need to have robust and responsive procedures in place for dealing with patients and members of the public who make contact with specific issues or queries relating to individual registrants, or indeed about wider matters.

**4.5** In order to deal with the first of these, engaging effectively with the public in a general sense, each regulator will have to work out its own strategy and this may well vary.

**4.6** The current regulators have established the Joint Health and Social Care Regulators Patient and Public Involvement Group to act as a corporate resource to the regulators to provide advice and support on this issue, which has proved to be effective. For example, this group commissioned and managed research into what information patients and the public wanted to see on the public versions of the registers, and as a result in many cases regulators have provided enhanced access to such information. The group has also produced and distributed a leaflet setting out which regulator is responsible for each health profession. **It is recommended that all healthcare professional regulators should continue to participate in this group and that each regulator should have an agreed set of arrangements which demonstrate that they are actively engaged with and involving patients and the public.**

**4.7** There are a number of examples from outside the regulatory bodies of what appear to be effective ways of engaging and involving patients and the public. These mechanisms are designed both to understand how public views and attitudes may be changing and to test out ideas that the regulator may be pursuing.

**4.8** One approach that has much to commend it is the Citizen's Council run by the National Institute for Health and Clinical Excellence (NICE). The 30 members of the Citizens Council are recruited by independent facilitators at arm's length from NICE from more than 4000 people who responded to widespread publicity. Applications from groups such as NHS employees, suppliers to the NHS, patient groups and those who work in lobbying organisations were declined. The Council meets twice a year and provides advice in response to a specific question of importance to NICE. The members of the Citizens Council serve for three years and are then replaced on a rolling basis by new recruits.

**4.9** The work of the Care Commission in Scotland was also cited. The Regulation of Care (Scotland) Act 2001 requires the Care Commission to organise a 'National

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Advisory Forum', which must meet at least twice a year to seek views on the work of the Care Commission. Any interested person can attend, and can raise an issue at a Forum meeting by submitting it in writing five days in advance of the national meetings.

**4.10** In order to fulfil the second requirement, that patients know about the regulator and how to make contact with it, **regulators need to ensure that all employers understand clearly when complaints should be referred.** The White Paper also indicates that CHRE should work with regulators to provide guidance to employers on when cases should be referred to the national professional regulators.

**4.11** **It is equally important that practitioners who are self employed or operating as independent contractors are required to make their patients aware of the regulator's existence and how it can be contacted.** In these settings it is even more important that patients are made aware of the standards of practice they can expect and that they understand that the regulator has a role in assuring that these standards are met.

**4.12** The third area concerns patients who have a query, intend to submit a complaint or wish to raise a particular issue. In part this is about regulators ensuring that they are operating a clear, responsive and timely service and have the policies, processes and monitoring systems in place to demonstrate that they are working well. **They should also have procedures that enable the organisation to learn from each case, in terms both of its own operation and any wider issues for registrants.** Following up complainants, including those whose complaint has not been taken forward, is an excellent source of learning.

**4.13** As has been noted above, many health professionals work outside the NHS, and many are self employed. In such cases there may be no means of raising issues about a practitioner other than by contacting the regulator - this places an additional responsibility on the regulator. **Council members should be engaged in ensuring complaints and fitness-to-practice processes are responsive, and where the council retains responsibility for running the adjudication process lay involvement on panels will continue to be vital.**

- **Registrants**

**4.14** An effective regulator requires the broad support of those whom it regulates, and it is vital that the regulatory body is in touch with practitioners' concerns and aspirations. The aim should be to achieve a shared view about the standards expected of a good practitioner, accepting that this will change over time. It is probably fair to say that different professions regard their regulators in different ways - in some small professions the regulator is seen as a champion of the professional cause, in others it may be regarded by some with a degree of suspicion and fear.

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**4.15** The current reforms certainly demand a significant mind-shift for those who viewed professional self-regulation as meaning that the regulators 'belonged' to the profession rather than being an authority whose purpose was public protection and that was charged with ensuring good standards of conduct and practice.

**4.16** There is an obvious danger here. The creation of smaller councils that are reflective rather than representative could, in theory, alienate registrants if they are not in touch with professional opinion. The fact that registrants pay for the running of the regulator could exacerbate this, which is why regular reporting on the work and performance of the regulator, including a report on its value for money are important. As noted above, there should be a requirement for the findings of the annual CHRE performance review, which should include a value-for-money component, to be made available to all registrants.

**4.17** However, it is worth noting that as councils adopt a more strategic focus, detailed issues relating to individual professions may be less likely to require decisions at council level. The Health Professions Council, which regulates 13 professions, reports that profession-specific issues are rarely discussed at council meetings.

**4.18** There will, of course, need to be arrangements to have regular dialogue with professional bodies and a duty to consult them on relevant matters. **Councils should be able to demonstrate that they have these mechanisms and arrangements in place.**

**4.19 Regulators should also take steps to engage with individual registrants and to make it easy for registrants to engage with them.** A good regulator should be able to show it has good communication channels and that it uses appropriate ways of reaching out to all those on its registers - depending on the size of the regulator and its budget this could include devices such as road shows, presentations at conferences and seminars. An example of good practice is the Health Professions Council's regular public meetings which are held eight times a year in different parts of the country.

**4.20** Current regulation assumes compliance with the codes of practice, but even when these are sent out there is often no requirement on the registrant to confirm that they have read the material. If there is to be a genuine connection between the registrants and the regulatory body beyond the payment of an annual fee it may be that regulators will need to find mechanisms to ensure registrants have read the material and accept these standards. The new revalidation processes should also help improve engagement, as this will require ongoing dialogue between registrants and the regulator. As with complainants, it is vital that clear and frequent feedback loops are in place for registrants who are subject to fitness-to-practice proceedings or failed revalidation- the various defence societies and other related bodies have a role to play in achieving this.

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**4.21 One suggestion made within the group was the instigation of a 'rite of passage' for new registrants, where registrants are asked to agree to uphold the Code of Practice. This is an idea regulators may wish to consider.** The regulatory bodies also reflected on the difficulties in engaging with overseas registrants who are not always aware of UK systems for regulation. It was felt that this "rite of passage" would also be a useful mechanism to engage with this group.

- **Employers**

**4.22** Regulators need to have close and ongoing relationships with all employers of healthcare professionals where this is applicable, including those working outside the NHS, some of whom will be small and medium sized businesses, and even multinational businesses, although recognising that many professions operate as independent practitioners. Engagement with employers is even more critical in light of the new requirements for revalidation.

**4.23** Engagement with employers needs to be more than just at the level of the individual registrant around fitness-to-practice issues. It is also important to engage with employers at a policy level to ensure the regulator can effectively reflect the current context within which their registrants are operating.

**4.24** There are already various examples of good practice - the Nursing and Midwifery Council holds employer summits in the four parts of the UK, the General Dental Council holds regular meetings with the professional associations and open days for primary care organisation dental leads and the General Medical Council has an Independent Sector Working Group.

- **Educators**

**4.25** Most regulators have specific duties in relation to undergraduate education and therefore should have close working relationships with higher education institutions and other relevant qualifications and curriculum authorities. As with some registrants it is inevitable that there will be tensions with individual educational establishments and courses, but overall regulators should be aiming to retain the confidence and support of educators preparing the next generation of practitioners.

**4.26** There was some support for the idea of requiring all undergraduate students studying for a professional qualification to register at or near the start of their course. Another view was that all undergraduate students should be subject to the authority of student fitness-to-practice committees within the university structure. **As a minimum it was felt that students should be aware from the outset, of the requirements of professional registration, and that education providers should establish and uphold standards of conduct for students, particularly as many of them now see patients early in their training.** Student registration, or at least an awareness of what full registration demands, might prevent a current problem - students who commit offences during their education and discover only on completion of their courses find that their convictions lead to denial of registration.

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**4.27** The working group also discussed the issue of overseas educators who are not regulated by the UK authorities but whose graduates have automatic rights to registration in the UK. The working group was clear that revalidation standards will be critical in ensuring effective and appropriate practice from all registrants, no matter where they received their education.

## **5. Size and composition**

**5.1** The White Paper states that the councils should, as a minimum, have parity of membership between lay and professional members, have members that are independently appointed, and become smaller and more board-like, with greater consistency of size and role across the professional regulatory bodies.

**5.2** During the course of our deliberations there was widespread support for the move from elected to appointed members and for councils that were constructed to reflect the views of all the key constituencies, instead of elected members who could be seen to 'represent' sectional interests.

**5.3** Given that the various councils are all performing the same function, one option going forward would have been to specify the same size of membership for each regulator. However, given the different histories and traditions and the fact that they do face very different challenges, not least in the scale and complexity of the professions they are regulating, there was recognition that some variation in size and membership would be inevitable for the foreseeable future. Nevertheless it was agreed that certain principles should underpin the make-up of every regulator.

- a. The composition of the council should reflect the changing nature of healthcare delivery. **The group recognised that councils needed to be able to reflect the interests and concerns of its key constituencies, but also that all members should be clear that their overriding purpose was the protection of patients and the public. No group should have guaranteed places on the council. Members, including those who were also registrants, should not be considered to be representative in any way - members should be appointed because of their knowledge, experience and judgement.**
- b. **Criteria should be set for the knowledge and skills required in the makeup of each council so that together members should possess the skills required to operate in an effective manner. One way to achieve this would be to ensure, *inter alia*, that the council has expertise in areas such as education, practice, patient experience and employing professionals.** When vacancies arise the aim would be to ensure that the council remains 'balanced' with the right mix of skills and experience. It is established good practice that those serving on such public bodies should do so for a limited and specified period. **The working group recommends that maximum terms of office for all regulators should be two terms of four years.**

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- c. **Given fixed periods of office councils should aim to achieve regular turnover managed in a staggered fashion to ensure a degree of stability and continuity.** In appointing new boards following these changes the Appointments Commission will want to take into account the need for some continuity.
- d. The need to reflect the knowledge base of both educators and employers on the council as well as clinical and lay perspectives was stressed.
- e. Composition of the council should also reflect the fact that registrants operate in a variety of settings, and not just in the NHS.
- f. Given the White Paper's commitment to creating smaller councils operating in a board-like manner there is an expectation that all regulators will significantly reduce the number of members ahead of any legislation. The size of council currently varies considerably, although many have already moved towards smaller bodies or are about to do so.

**5.4** At this stage it would be unwise to impose a single size for each council - while the central purpose behind each regulator is the same, their immediate challenges are different as are the different constituencies they need to work with. Nevertheless, a council cannot operate in a 'board-like' manner if it is too large, an issue reflected in a range of literature on effective boards and decision-making,<sup>7</sup> and accordingly **it is recommended that regulators should aim for councils that are made up of between 9 and 15 members, recognising that some of the regulatory bodies may need to move incrementally towards this range.**

## **6. Role of committees**

**6.1** If councils are to work effectively in their strategic role, some of the detailed matters currently undertaken by councils will be carried out by committees within the regulatory body. As is normal good practice under the current arrangements, each committee should have clear terms of reference outlining explicit powers and reporting structure. In future, though, it will be important to ensure they have sufficient autonomy to debate and implement changes to avoid the council having to repeat discussions and ratify decisions.

**6.2** For some regulators the law currently requires that committees must be populated almost exclusively by council members, and for most committees are chaired by council members. Some in the working group felt that committees should be chaired by council members, and specifically lay members, but it was also argued that chairs and members could be drawn from a wider pool to ensure sufficient skills and knowledge were available. **It is therefore recommended that the requirement for some regulators to use council members exclusively to populate its committees be dropped and the same principle should be applied to investigating committees.**

**6.3** It was also agreed, in line with the White Paper recommendations, **that fitness-to-practice committees should no longer involve members of**

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<sup>7</sup> For a useful summary of research see National Council for Voluntary Organisations website <http://www.ncvo-vol.org.uk/askncvo/index.asp?id=594>

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**council and that the practice adjudicators should be drawn from a wider pool.** The Nursing and Midwifery Council has set up its own arm's length appointments board to recruit fitness-to-practice panellists and fill other committees and the General Dental Council created an independent appointments board for its fitness-to-practise panel in 2003.

**6.4** In terms of wider confidence and clarity of role, there is merit in going further and adopting an entirely independent adjudication process as will apply to the General Medical Council and the General Optical Council under the new arrangements. There are also advantages in terms of transparency and fairness in establishing a system whereby all professionals appearing before fitness-to-practice panels go through the same process. The government has indicated it will reconsider this question in 2011 - **it is recommended that all regulators seriously consider joining the independent adjudication scheme before that time.**

## **7. Role of council members**

**7.1** The role of council members is to hold the executive to account (within appropriate employment practices) and bring their knowledge, skill and experience to bear to ensure that all statutory duties are delivered in a cost-effective and appropriate manner. A generic/skills competency framework for council members should be developed, and examples of such a framework were submitted by regulators. The box below highlights a set of competencies developed by the General Chiropractic Council:

1. **Public interest/involvement focus**
  - demonstrates adherence to the Nolan principles of public life
  - demonstrates commitment to protecting patients and the public
  - demonstrates commitment to securing public/patient involvement
2. **Strategic direction**
  - demonstrates a comprehensive understanding of the regulatory body and the context in which it performs the full range of its statutory duties and responsibilities
  - thinks and plans based on the long view, balancing needs and constraints
  - demonstrates sound judgement
3. **Intellectual flexibility**
  - thinks clearly, analytically and creatively
  - sees the big picture as well as the detail
  - makes sense of complexity
  - weighs up other people's ideas and has own ideas
4. **Team working**
  - prepares well for meetings
  - builds constructive relationships and works effectively in a team
  - accepts and supports/promotes all decisions of council
  - understands and maintains the separation between the non-executive and executive function
  - allows the executive to carry out the operational work

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5. **Holding to account**
  - accepts own accountability while holding others to account for their performance
  - probes and challenges constructively
  - contributes to effective governance
6. **Effective influencing and communication**
  - respects the views of others
  - able to influence and persuade others
  - debates cogently
  - uses evidence to support views
  - is not resistant to change
7. **Self belief and drive**
  - is motivated to improve the performance of the regulator
  - has confidence to take on challenges
  - is enthusiastic to achieve a proper outcome

*With thanks to the General Chiropractic Council*

**7.2 It is recommended that all regulatory bodies draw up a generic skills and competency framework for council members. It is recommended that induction training should be consistent for both lay and professional members and consistent across the regulatory bodies.**

**7.3** Appraisal of council members is required by the Appointments Commission before reappointment, and formal annual appraisal systems have been developed by some regulators. **It is recommended that there should be a consistent approach to appraisal across the regulators, and training on the appraisal process should form part of every induction.** There was a view among some in the working party that 360-degree feedback was the standard to be aimed for, ensuring that any process is proportionate to the role.

**7.4** The White Paper states that councils will have chairs rather than presidents and that the question of whether chairs should be independently appointed will be reviewed in 2011.

**7.5** There was some support for the view that it may be better to appoint a chair with experience rather than the member able to attract most votes from his or her colleagues, but views on the group were divided on this. Some argued that it was up to individual regulators to choose their own chair, although it was acknowledged that the skill set required for chairs will be different from that of council members and that the remuneration and commitment were of a different order.

**7.6 One way round this would be to ask the Appointments Commission to identify individuals within each council when they are appointed whom it considers would be suitable as chairs and for any candidates to be restricted to those approved by the Commission in this way.** It should be pointed out that one member of the working group felt this would be divisive and would create two classes of council members.

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**7.7** There was a significant divergence of opinion within the working group as to whether the chair should be a lay or professional member - some of the group felt that it would be difficult for a lay chairperson to exercise a professional leadership role, but others questioned whether 'professional leadership' was actually a function of a regulatory body. Some also felt that in the current regulatory climate there could be an issue with public confidence if the chair was a registrant.

**7.8** It is hard to justify the argument that public confidence would be dented by having a professional as chair but equally hard to justify that a lay chair could not lead a professional regulator. **The question as to whether chairs are lay or professional is a second order issue, - the key factor is that they must have the skills and attributes to undertake the role and that should be determined externally by the Appointments Commission.**

**7.9** Council members should be paid an annual salary or honorarium in return for a specified number of days' work (for example two to three days per month). A per diem rate could then be paid for additional work, such as chairing committees. All expenses should be covered by the regulatory bodies.

**7.10** Some concern was expressed about the time commitment and availability of lay members who sit on numerous regulatory bodies, both within and beyond healthcare. **It was agreed that there should not be a cap on the number of appointments an individual could accept, but it is recommended that this be a matter for discussion at interview and that the Appointments Commission should issue guidance to interviewing panels to consider carefully time commitment and availability before appointing any individual.**

## **8. Equality and diversity**

**8.1** Strategic councils will require a range of skills, competencies and experience and this must include an understanding of diversity in the population. The registrant constituency may well be more ethnically diverse than the population as a whole, and this should also be reflected in the appointments process. There are difficulties in monitoring diversity within the registrant group, although this is being addressed by the regulatory bodies. **The establishment of the equality and diversity forum between the regulators is an important step in improving diversity, and all regulators should continue to participate actively in this forum.**

**8.2** It is important that the regulatory bodies work closely with the Appointments Commission in England, and other relevant bodies in Scotland, Wales and Northern Ireland, in maximising the coverage of advertisements. **It is recommended that the level of guidance in application packs should be reviewed to ensure that all candidates are given equal opportunity to improve their application.** Providing clear guidance in the application packs on what types of experience applicants can draw

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on will enable them to complete them more effectively, but requirements to have served in a senior, or board-level position should be avoided as many women, disabled people and those from black and minority ethnic communities are often under-represented at these levels.

**8.3 As part of their report to Parliament, regulators should set out how they have monitored and tackled issues of diversity and equality both within their organisations and in their dealings with key constituencies.**

## **9. Devolved administrations**

**9.1** Although the devolved administrations are able to legislate for a small number of professions, and in future for any professions that are to be regulated for the first time in their own right, there is currently a commitment to UK-wide regulation. Nevertheless there are now different health systems operating in each part of the UK which are controlled by devolved administrations. It is likely that the way healthcare is run will increasingly differ across the UK over the coming years. It is clearly important therefore that the regulatory bodies have the confidence of the devolved administrations. **It is important for the regulatory bodies to understand the different contexts facing services in each country, especially but not exclusively in relation to NHS services. That means that each regulator will need to have formal mechanisms through its committee structure for ensuring that its outputs are relevant and appropriate in each domain.**

**9.2** Furthermore, while most powers over healthcare professional regulation are reserved to the UK Parliament, in Scotland, for example, the regulation of operating department practitioners, certain professions complementary to dentistry, and new professions is a devolved responsibility and the training of registrants can also differ. **In addition, the Appointments Commission only operates in England, and it is recommended that arrangements should be made to ensure that its work is co-ordinated with the relevant bodies in the other parts of the UK for appointments to UK wide regulators.**

**9.3** The same principles of engagement applied to other key groups should therefore be applied to the devolved administrations - the details of how this will operate must be a matter to be resolved between governments, but it is recommended that the principle that councils should be 'reflective' rather than 'representative' should extend to this dimension as well. **The membership of each council should reflect in broad terms the skills, experience and competencies needed to fulfil its remit as a UK regulator.**

**Niall Dickson**  
November 2007

**Summary of Recommendations**

1. Each regulator should publish a set of key performance indicators after discussion with the Council for Healthcare Regulatory Excellence (CHRE). *2.1*
2. Schemes of delegation to be developed by all councils. *2.2*
3. An amended version of the twelve principles reflecting the particular role played by councils of professional regulators should be adopted by every regulator. *2.3*
4. Government should consider bringing together the accountability for the register with that of the regulatory body as a whole for those regulators to whom this does not already apply. *3.5*
5. CHRE should provide the UK Parliament, and where appropriate the Scottish Parliament, with an assessment of performance of each regulator which should look back at the year past as well as consider future plans.
6. Regulators should have a duty to submit a strategic plan and annual report to the UK or Scottish Parliament. *3.7*
7. Parliament should consider establishing a standing committee of both Houses of Parliament to oversee professional regulators in health. *3.8*
8. Regulators should be required to make a report available each year to every registrant that includes a copy of the CHRE assessment on their performance. *3.12*
9. All healthcare professional regulators should continue to participate in the Joint Health and Social Care Regulators Patient and Public Involvement group and each regulator should have an agreed set of arrangements which demonstrates that they are actively engaged with and involving patients and the public. *4.6*
10. Regulators should ensure that all employers understand clearly when complaints should be referred. *4.10*
11. Practitioners who are self employed or operating as independent contractors should be able to demonstrate that their patients are aware of the regulator's existence and how it can be contacted. *4.11*
12. Regulators should have procedures which enable the organisation to learn from each case, both in terms of its own operation as well as any wider issues for registrants. *4.12*
13. Council members should be engaged in ensuring complaints and fitness-to-practice processes are responsive and where the council retains responsibility for running the adjudication process lay involvement on panels will continue to be vital. *4.13*
14. Councils should be able to demonstrate that they have these mechanisms and arrangements in place for regular dialogue with professional bodies. *4.18*

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15. Regulators should take steps to engage with individual registrants and to make it easy for registrants to engage with them. *4.19*
16. Regulators should consider the instigation of a 'rite of passage' for new registrants, where registrants are asked to agree to uphold the Code of Practice. *4.21*
17. As a minimum students should be aware at the outset of their training of the requirements of professional registration, and education providers should establish standards of conduct for students and uphold them. *4.26*
18. No group should have guaranteed places on the council. Members, including those who are also registrants, and should not be considered to be representative in any way - members should be appointed because of their knowledge, experience, and judgement. *5.3a*
19. Criteria should be set for the knowledge and skills required in the makeup of each council so that together members should possess the skills required to operate in an effective manner. *5.3b*
20. The maximum terms of office for all regulatory councils should be two terms of four years. *5.3b*
21. Councils should aim to achieve regular turnover managed in a staggered fashion to ensure a degree of stability and continuity. *5.3c*
22. Regulators should aim for councils that are made up of between 9 and 15 members, recognising that some of the regulatory bodies may need to move incrementally towards this range. *5.4*
23. The requirement for some regulators to use council members exclusively to populate its committees be dropped and the same principle should be applied to investigating committees. *6.2*
24. Fitness-to-practice committees should no longer involve members of council, and practice adjudicators should be drawn from a wider pool. *6.3*
25. All regulators should seriously consider joining the independent adjudication scheme before 2011. *6.4*
26. All regulatory bodies should draw up a generic skills and competency framework for council members. *7.2*
27. Induction training should be consistent for both lay and professional members and consistent across the regulatory bodies. *7.2*
28. There should be a consistent approach to appraisal across the regulators, and training on the appraisal process should form part of every induction. *7.3*
29. The Appointments Commission should consider identifying individuals within each council when they are appointed whom it considers would be suitable as chairs and that candidates be restricted to those approved by the Commission in this way. *7.6*
30. Chairs must have the skills and attributes to undertake the role and that should be determined externally by the Appointments Commission. *7.8*

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31. Council members should be paid an annual salary or honorarium in return for a specified number of days' work (for example two to three days per month). A per diem rate can then be paid for additional work, such as chairing committees. All expenses should be covered by the regulatory bodies. *7.9*
32. There should not be a cap on the number of appointments an individual can accept, but this should be a matter for discussion at interview and the Appointments Commission should issue guidance to interviewing panels to consider carefully time commitment and availability before appointing any individual. *7.10*
33. All regulators should continue to participate actively in the joint equality and diversity forum. *8.1*
34. The regulatory bodies should work closely with the Appointments Commission in England, and other relevant bodies in Scotland, Wales and Northern Ireland, in maximising the coverage of advertisements. *8.2*
35. The level of guidance in application packs should be reviewed to ensure that all candidates are given equal opportunity to improve their application. *8.2*
36. As part of their report to Parliament regulators should set out how they have monitored and tackled issues of diversity and equality both within their organisations and in their dealings with key constituencies. *8.3*
37. Each regulator will need to have formal mechanisms through its committee structure for ensuring that its outputs are relevant and appropriate in each of the four countries. *9.1*
38. As the Appointments Commission only operates in England, arrangements should be made to ensure that its work is co-ordinated with the relevant bodies in the other parts of the UK for appointments to UK-wide regulators. *9.2*
39. The membership of the council should reflect in broad terms the skills, experience and competencies needed to fulfil its remit as a UK regulator. *9.3*

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**Appendix 2**

**Membership of the Working Group**

Niall Dickson (Chair)	Chief Executive	King's Fund
Gail Adams	Head of Nursing	Unison
Penny Bennett	Regional Commissioner for South West	Appointments Commission
Paul Buckley	Director of Strategy and Planning	General Medical Council
Joyce Cairns	Workforce Planning Unit	DHSSPSNI
Harry Cayton	Chief Executive	Council for Healthcare Regulatory Excellence
Catherine Clark	Head of Regulatory Unit	Scottish Government Health Department
Margaret Coats	Chief Executive and Registrar	General Chiropractic Council
Carol English	Professional Officer	Unitetheunion
Margaret Goose	Chair of the Royal College of Physicians, London, Patient and Carer Involvement Steering Group	Patient Representative
Vivienne Heckford	General Manager Doctor Engagement	Nuffield Hospitals
Nancy Kirkland	President	Nursing and Midwifery Council
Dr Surendra Kumar	President, British International Doctors Association and GPC member	British Medical Association
Dr Paul Langmaid	Chief Dental Officer	Department for Health and Social Services, Welsh Assembly Government
Hew Mathewson	President	General Dental Council
Dr Keith Ridge	Chief Pharmaceutical Officer (Chair of the "Pharmacy Oversight Group)	Department of Health

**Paper from the Council for Healthcare Regulatory Excellence for Enhancing Confidence Working Group, 6 November 2007**

**1. Introduction**

CHRE was asked to identify characteristics of an effective board, and to provide information on the boards of organisations regulating professional groups outside health.

In response to the first of these requests, we looked at available key publications on governance and on the guidance specific to health. Having done so, we felt that John Carver's *Boards that Make a Difference* (Third Edition 2006) offered the most relevant and sensible advice, focussed on the public/not for profit sector, and widely respected. Although published in the US, it makes reference to and uses examples from the UK public sector. It also reflects wider developments in corporate governance, such as the Cadbury Report (1992) and Sarbanes-Oxley legislation.

In section two of this paper we offer our suggested 12 key principles for an effective board. In section three, we give an extract from Carver which gives examples of the kinds of activity which boards should and should not do, which we hope will be helpful in making more tangible the abstract principles set out in section two. At section four we give some further references.

In response to the second part of the request, in section five of this paper we look at six regulatory bodies outside health. We offer a summary of the purpose of each, the number of registrants, the composition of the board/council, the percentage of the board/council who are lay members, and the method of appointment. We also offer some overarching analysis.

**2. 12 key principles for an effective board**

We offer below 12 generic principles for an effective board. The Working Group may wish to reflect on how these principles could be translated in the specific context of a regulatory body. For example, where organisational purpose is set out in statute how can a regulatory body create sufficient flexibility to adapt to changes in the outside world? Who is the owner of the regulatory bodies? We would argue that given regulatory bodies' objective to protect promote and maintain the health, safety and well-being of members of the public, it is the public who should be considered the ownership on whose behalf the board act. Therefore it is the views and priorities of the public that the board must be confident it understands, through continuous engagement.

- The board should determine the purpose and values of the organisation, and review these regularly

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- The board should be forward and outward looking, focussing on the future, assessing the environment, engaging with the outside world, and setting strategy
- The board should determine the desired outcomes and outputs of the organisation in support of its purpose and values
- For each of its desired outcomes and outputs, the board should decide the level of detail to which it wishes to set the organisation's policy
- Any greater level of detail of policy formulation should then be a matter for the determination of the chief executive and staff
- The means by which the outcomes and outputs of the organisation are achieved should be a matter for the chief executive and staff; the board should not distract itself with the operational matters
- The chief executive should be accountable to the board for the achievement of the organisation's outcomes and outputs
- In assessing the extent to which the outcomes and outputs have been achieved, the board must have pre-determined criteria which are known to the chief executive and staff
- The board should engage with its ownership regularly and be confident that it understands its ownership's views and priorities
- The membership of the board should be capable and skilled to represent the interests of the ownership; this should not be done in a tokenistic way
- Information received and considered by the board should support one of two goals – to enable decision making, or to fulfil control and monitoring processes
- The board must govern itself well, with clear role descriptions for itself, its chair, and its members, with agreed methods of working and self-discipline to ensure that time is used efficiently

**3. Hands on versus hands off tasks for the board**

The following table is extracted from *Boards that Make a Difference* (Carver 2006, pg 175 Exhibit 6.3) and offers some tangible examples of the kinds of activity that effective boards should and should not undertake.

<b>Hands on – examples of what the board should do</b>	<b>Hands off – examples of what the board and its chair should keep hands off</b>
Set the board's work plan and agenda for the year and for each meeting	Establish services, programs, curricula, or budgets

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Determine board training and development needs	Approve the CEO's personnel, program or budgetary plans
Attend to discipline in board attendance, following bylaws and other rules	Render any judgements or assessments of staff activity for which no previous board expectations have been stated
Become expert in governance	Determine staff development needs, terminations, or promotions
Meet with the ownership	Design staff jobs or instruct any staff member subordinate to the CEO (except when the CEO has assigned a staff member to some board function)
Establish the limit's of the CEO's authority to budget, administer finances and compensation, establish programs, and otherwise manage the organisation	Decide on the organisational chart and staffing requirements
Establish the results, recipients, and acceptable costs of those results that justify the organisation's existence	Establish committees to advise or help staff
Examine monitoring data and determine whether the organisation has achieved a reasonable interpretation of board-stated criteria	

#### **4. Some further reading**

##### **(i) General**

Report of the Committee on the Financial Aspects of Corporate Governance (The Cadbury Report) (1992)

The Greenbury Report (1995), on the role of remuneration committees

The Hempel Report (1998), on the composition and balance of boards

The Smith Report (2003), on audit committees

Financial Services Authority combined Code on Corporate Governance (2003)

##### **(ii) NHS specific**

Bevington J, Saunders M, Bird S, Dixon P, Buggins E (2005). *Improving the performance of NHS boards*. In View, Issue 7, September 2005 pp14-19

Corbett-Nolan A, Malcolm A (1999). *Quality improvement and assurance in the NHS – confidence levels of NHS Trust Boards*. London: King's Fund; Health Quality Service.

Deffenbaugh J (1996). *Understanding the roles of NHS trust board members*. Journal of Management in Medicine. Vol 10, Iss. 2; pg 54

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Department of Health (2006). *NHS Foundation Trusts: a sourcebook for developing governance arrangements*. Version D: 12 January 2006. London: Department of Health.

Department of Health (2006a). *Integrated Governance Handbook: a handbook for executives and non-executives in healthcare organisations*. London: Department of Health.

Dr Foster 2006. *The Intelligent Board*. London: Dr Foster

NHS Appointments Commission (2003). *Governing the NHS, a guide for NHS boards*. London: NHS Appointments Commission

NHS Confederation (2005). *Effective boards in the NHS?* London: NHS Confederation.

Robinson R, Exworthy M (1999). *Two at the top: a study of working relationships between chairs and chief executives at health authorities, boards and trusts in the NHS*. London: NHS Confederation.

Stanton P (2006). *The role of an NHS Board in assuring the quality of clinically governed care and the duty of trust to patients*. *Clinical Governance* 2006 Vol 11, Iss 1; pg 39

University of Plymouth (2006). *An exploratory study of the clinical content of NHS trust board meetings, in an attempt to identify good practice*. London: The Burdett Trust for Nursing.

### **5. Governance structures of regulatory bodies outside health**

In this section of the paper we give a summary of the governance structures of six professional regulatory bodies in the United Kingdom from outside the healthcare professions. The regulators considered are the Architects Registration Board, the General Teaching Council for England, the General Social Care Council, the Farriers Registration Council, the Solicitors Regulation Authority, and the Bar Standards Board. All of the regulators are members of the United Kingdom Inter-Professional Group, which acts as a forum for the major professional and regulatory bodies, with the exception of the GTC.

The majority of the regulators reviewed (four out of six) do not have lay majorities on their board/council. The two regulators with lay majorities were the ARB (53%) and the GSCC (60%). The ARB has a professional minority elected by registrants, with the board electing its own chair from amongst its number. The GSCC, on the other hand, has a professional minority appointed in the same manner as its lay majority, and an appointed chair. Of the four regulators with lay minorities, three had sizeable minorities in the range of 44% to 47%. Only the GTC had a small lay minority (23%). We have taken the definition of lay to be someone who is not, nor who has ever been, a registered member of the profession that is regulated by the body on the board/council of which they sit.

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There is no consistency in the appointments processes to either board/council membership or the position of chair. In addition to public appointments and elections, some regulators have arrangements for stakeholders from within the profession, and from outside the profession, but with an interest in it, to nominate members to the board/council.

With regard to the legal professions, the Legal Services Bill, which received its second hearing on 4 June 2007, proposes to create a new Legal Services Board. This will oversee the work of the front-line regulators, including the Solicitors Regulation Authority of the Law Society and the Bar Standards Board of the Bar Council. To receive authorisation from the LSB, front-line regulators must demonstrate that regulatory functions are clearly separated from all other functions carried out by the professional body, such that regulation takes place in the public, and not professional, interest.

Name of Regulatory Body, its jurisdiction, & number of registrants	Purpose	Number of Board/Council Members	Method of appointment to Board/Council
Architects Registration Board; United Kingdom; 31,522 (2006)	<ul style="list-style-type: none"> <li>• Maintain a register of architects</li> <li>• Prosecute unregistered individuals posing as architects</li> <li>• Promote good standards of education and prescribe qualifications</li> <li>• Operate complaint service</li> </ul>	15 (53% lay)	<ul style="list-style-type: none"> <li>• 7 architects elected by registered members</li> <li>• 8 appointed by Privy Council in consultation with the relevant Secretary of State (currently Communities and Local Government)</li> <li>• Board elects its own Chair</li> </ul>
General Teaching Council for England 538,343 (2006)	<ul style="list-style-type: none"> <li>• Maintain a register of all qualified teachers</li> <li>• Advise government and other key agencies (statutorily)</li> <li>• Regulate the conduct and competence of teachers</li> </ul>	64 (23% lay <sup>1</sup> )	<ul style="list-style-type: none"> <li>• 25 teachers elected by registered members</li> <li>• 9 appointments by teaching unions</li> <li>• 13 appointed by the Secretary of State through the public appointments process, some of whom are/have been teachers</li> <li>• 17 appointments by</li> </ul>

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			organisations connected with the teaching profession (inc Local Government Association (x3), Commission for Racial Equality, Disability Rights Commission, CBI)
General Social Care Council England 91,530 (2007)	<ul style="list-style-type: none"> <li>• Maintain the Social Care Register</li> <li>• Set codes of practice for social care workers and employers</li> <li>• Approve education and training programmes</li> </ul>	10 (60% lay <sup>2</sup> )	<ul style="list-style-type: none"> <li>• Appointments are made by the Appointments Commission on behalf of the Secretary of State</li> <li>• Chair and majority of council members are lay, by statute (though size of majority not specified)</li> <li>• Currently 6 lay and 4 professional members</li> </ul>
The Farriers Registration Council England, Wales & Scotland 2,555 (2006)	<ul style="list-style-type: none"> <li>• Maintain a register of farriers</li> <li>• Approve and supervise qualifications and institutions providing training in farriery</li> <li>• Investigate and determine cases of misconduct cases</li> </ul>	16 (44% lay)	<ul style="list-style-type: none"> <li>• 3 appointments, including to the Chair, by the Worshipful Company of Farriers (small self-selecting body promoting farriery and operating examinations)</li> <li>• 2 appointments by the National Association of Master Farriers, Blacksmiths and Agricultural Engineers (professional association)</li> <li>• 4 farriers elected by the registered membership</li> <li>• 2 appointments by the Royal College of Veterinary Surgeons</li> <li>• 5 appointments by other organisations with an interest in the farriery profession</li> </ul>
Solicitors Regulation Authority England & Wales 131,347 (2006)	<ul style="list-style-type: none"> <li>• Formally part of the Law Society for administrative and legal reasons, but with operational independence from it</li> <li>• Administers the register of solicitors</li> <li>• Sets standards for qualification</li> <li>• Monitors organisations</li> </ul>	16 (44% lay)	<ul style="list-style-type: none"> <li>• 9 solicitors, including the Chair (none of whom can serve simultaneously on the Law Society's council)</li> <li>• 7 lay members</li> <li>• All appointments are made by the Law Society in accordance with the guidance issued by the</li> </ul>

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	<ul style="list-style-type: none"> <li>• providing legal training</li> <li>• Sets CPD requirements for solicitors</li> <li>• Drafts rules of professional conduct</li> <li>• Investigate concerns about standards of practice and compliance with rules, where appropriate taking action (e.g. reprimand)</li> <li>• Refer solicitors to the independent and statutory Solicitors Discipline Tribunal (of 2 solicitors, 1 lay) and prosecutes the cases</li> </ul>		<p align="center">Commissioner for Public Appointments</p>
<p>Bar Standards Board England &amp; Wales 14,890 (2006)</p>	<ul style="list-style-type: none"> <li>• Formally part of the Bar Council for administrative and legal reasons, but with operational independence from it</li> <li>• Sets educational and training requirements for becoming a barrister</li> <li>• Sets CPD requirements for barristers</li> <li>• Sets standards of conduct for barristers</li> <li>• Monitors the service provided by barristers to assure quality</li> </ul> <p>Investigates complaints and takes forward conduct cases to face independent panels (with a professional majority of 1 person)</p>	<p align="center">15 (47% lay)</p>	<ul style="list-style-type: none"> <li>• 8 barristers (none of whom can serve simultaneously as a member of either the Bar Council or any of its representational committees)</li> <li>• 7 lay members, including the Chair</li> <li>• All appointments are made by the Bar Council in accordance with the guidance issued by the Commissioner for Public Appointments</li> </ul>

<sup>1</sup>The 13 appointees of the Secretary of State and the 17 appointees of organisations connected with the teaching profession may be lay or non-lay, hence the figure for the percentage of lay members on the council is subject to change according to the particular appointees to it.

<sup>2</sup>Statute specifies that a majority of members must be lay (as the chair must be also), not any particular size of majority, hence it is possible for this percentage to change with changes in the composition of the council.

**Implementing the White Paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulators - final report and DH response to recommendations**

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