The future shape of the Accredited Registers programme

Report on the public consultation

April 2021

professional™ standards authority

accredited register

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

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1. Executive summary

1.1 In 2012, the government placed a statutory requirement on the Authority to accredit voluntary registers of health and social professionals and workers. The Authority set up and has run the programme since that date. In 2020, we carried out a strategic review to determine whether the programme could become financially self-sustaining and what changes might be needed to protect the public. This report sets out the results of the public consultation we conducted as part of that review.

1.2 The Health and Social Care Act 2012 sets out that our functions under this legislation are:

1) to promote the interests of users of health care, users of social care in England, users of social work services in England and other members of the public in relation to the performance of voluntary registration functions,

2) to promote best practice in the performance of voluntary registration functions, and

3) to formulate principles of good governance in the performance of voluntary registration functions and to encourage persons who maintain or operate accredited voluntary registers to conform to those principles.

1.3 Today, the Accredited Registers programme covers 25 registers and approximately 100,000 practitioners. This includes approximately 60 different types of occupation including counsellors, psychotherapists, health scientists, public health practitioners, complementary therapists and homeopaths. Practitioners work in a variety of settings including independent practice, the NHS, education, and voluntary organisations.

1.4 This is the first time since the programme was introduced in 2012 that we are undertaking a thorough review of its effectiveness. We recognise that despite our best efforts, the programme has not achieved the levels of recognition and use which were originally envisaged. On its introduction, the Department of Health and Social Care (DHSC) agreed to provide funding whilst the programme was established, provided it achieved self-funding status by April 2021. The programme has not yet reached this position which represents an unacceptable financial risk to the Authority. There are also legal and reputational risks associated with the accreditation of some registers where evidence of the effectiveness of the treatments provided by their registrants is low or contested.

1.5 There are also opportunities. There have been significant changes in the wider health and social care environment since the programme was introduced. These suggest the potential for the programme to make a greater contribution within the wider health and social care systems – provided that the assurance it provides is wanted and supported by Government, the NHS, social care, the independent sector and patients and service users. For these reasons we decided to carry out a strategic review of the programme to consider whether it is an appropriate way of overseeing the registers within its scope.

1.6 Our consultation on the future of the Accredited Registers programme ran from 11 December to 18 February 2021. We sought views from the public, employers, current Accredited Registers, and other stakeholders about how accreditation of registers of health and social care roles that don't have to be regulated by law, can best protect patients and other users of their services.

1.7 The consultation was an important part of our strategic review of the programme, which began in June 2020. During the first phase of our review, we considered whether the programme had met the original aims for it as set out in the Government's White Paper, *Enabling Excellence*, eight years from its introduction. We concluded that whilst we could chart improvements made by all the organisations we have accredited during this time, for the programme to reach its potential there needs to be greater recognition and use, particularly by employers. It is also essential that the programme becomes self-funding to mitigate the potential financial risks and we need to ensure that the programme manages risks more effectively to mitigate against the legal and reputational risks to the Authority.

1.8 Our consultation set out three main changes to the programme to achieve this, for introduction later this year. We set out proposals for immediate changes to make the way we assess registers more proportionate to risk. We also outlined plans for a revised funding model to enable the programme to become self-funding within 2021/22. Finally, we sought views on whether we should take greater account of evidence about the efficacy (or effectiveness) of treatments offered by the registrants on the registers we accredit.

1.9 We also set out our vision for the future of the programme in the context of the wider regulatory system. We proposed that there should be a clearer mechanism for determining which professions must be registered by law, based on risk, as a first step. We envisaged the use of controls such as licensing for more 'intermediate risk' professions.

1.10 Our consultation survey included nine questions. We received 84 full responses from a range of stakeholders including Accredited Registers, practitioners, employers and patients and patient groups, a full breakdown is provided under section 3. Some of the organisations who responded had surveyed their members, which broadened our reach. We also held three events to engage with key stakeholders during the consultation period.

1.11 The findings showed broad support for our plans to introduce a longer assessment cycle, and clearer minimum standards for organisations applying for accreditation. This was seen as an effective way to ensure that we focus our resources in a targeted way. Responses about our funding model showed a greater mix of views, but overall respondents generally agreed that moving to a per-registrant fee model was a reasonable way for us to achieve financial sustainability. Several respondents, including organisations that we currently accredit, suggested ways to limit the impact on larger registers.

1.12 There was generally high support for us to take greater account of evidence of efficacy in our accreditation decisions. This was particularly so from the patient groups and their members who responded to our consultation. Our stakeholder events also showed a high level of support for this from employers, UK Government and NHS bodies.

1.13 However, views about the best way to achieve this were mixed. Of the three options that we consulted on, there was greatest support for introducing a minimum acceptable evidence base. However, the comments we received highlighted the challenges of implementing this in practice, particularly for areas of health and care that currently rely on user-reported outcomes.

1.14 Responses to our future vision were mixed, with approximately equal proportions of those who agreed, disagreed and weren't sure if our longer-term proposals would achieve greater recognition and use of the programme, without more fundamental change to the system itself. Many respondents across each of these categories highlighted the importance of considering the programme within the context of changes to statutory regulation. There was strong support for us to pursue the legislative changes that would enable Accredited Registers to access the same level of criminal record checks as employers, which we will pursue in parallel to the changes we propose to introduce later this year.

1.15 Since our consultation closed, Government has published its White Paper setting out legislative changes for a Health and Care Bill. On 24 March 2021, it published a consultation on proposals to reform the regulation of healthcare professionals. Together, these proposals signal future changes that will have a significant impact on the boundaries of statutory, and non-statutory regulation. We will continue to work with Government to ensure that our longer-term vision for the programme is embedded within these plans.

1.16 Overall, the support we received through our consultation has brought clarity about the changes we must make to ensure that the programme delivers the protections that patients, the public and employers expect. We are considering the suggestions made about our approach to evidence of efficacy, and how we might accommodate as part of an approach which focuses on whether the decision to accredit an organisation is within the best interests of the public.

1.17 We will continue to assess the impact of our proposals on those most likely to be affected, as we develop them. We will issue a further public statement after our Board meets in May 2021, ahead of our anticipated date to introduce the changes in July 2021.

2. Background – why we consulted

2.1 Through our Accredited Registers programme, we provide assurance for roles in health and social care that are not required to be regulated within the UK. We do this by accrediting organisations which hold registers of these roles, who meet our Standards for Accredited Registers. To be accredited, organisations must demonstrate good levels of governance, complaints handling, registration and education and training.

2.2 The aim of accreditation is to give the public, employers and other stakeholders confidence when choosing services from registered practitioners. Our Accredited Registers currently cover over 60 roles, including counselling, psychotherapy, health science and complementary therapies. They work in a variety of settings including hospitals, schools, private clinics, and people's homes.

2.3 The purpose of the consultation was to seek views on our proposals on the future shape of accreditation. We know that to reach its potential, there needs to be higher levels of awareness, greater use and recognition by employers, and confidence in the standards maintained by the registers and their practitioners.

3. Who responded?

3.1 Our consultation ran from 12 December until 18 February 2021. We published a survey with nine questions. We received a total of 84 full responses which were provided against the consultation questions. We received 13 responses in a different format. Although we were not able to include these in the quantitative analysis in this report, we have considered the comments provided.

Which stakeholders responded?
The breakdown by stakeholder group of the 84 full responses to our consultation:

- Accredited Registers and associated organisations: 40%
- Registers not accredited by us: 11%
- Employers: 2%
- Patients/public/Patient groups: 2%
- Practitioners: 20%
- Public bodies, such as the NHS and Government: 7%
- Other and unknown: 18%

In addition, the Patients Association surveyed 105 of its members to inform its response. The response from NHS Employers was also informed by requests from its members.

3.2 The largest stakeholder group to respond to our consultation was organisations which are accredited by us (40%). Although, one organisation, the Patients Association, used a survey of 105 of its members to inform its response. The response from NHS Employers was also informed by requests from its members.

3.3 In addition to the consultation survey, we ran three events to engage with key stakeholders on the proposed changes. These were held virtually in December 2020 and January 2021. We did this to make it easier for stakeholders to respond, since we knew the Covid-19 pandemic and UK-wide restrictions could impact on their ability to engage during the period our consultation ran for. These events were attended by representatives from the four UK governments, patient groups, NHS bodies, employers, and representatives from the independent sector. A list of the events is at Annexe A.

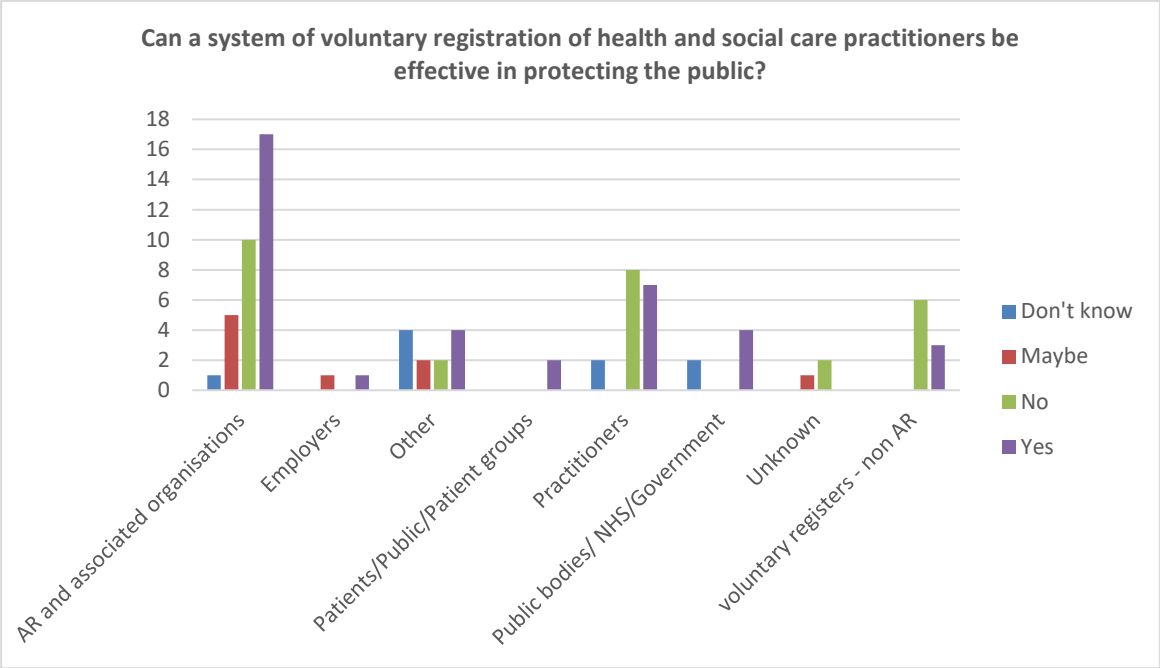
4. The findings

Can a system of voluntary registration of health and social care practitioners be effective in protecting the public?

4.1 Respondents were asked to state whether they agreed that a system of voluntary registration of health and social care practitioners can be effective in protecting the public.

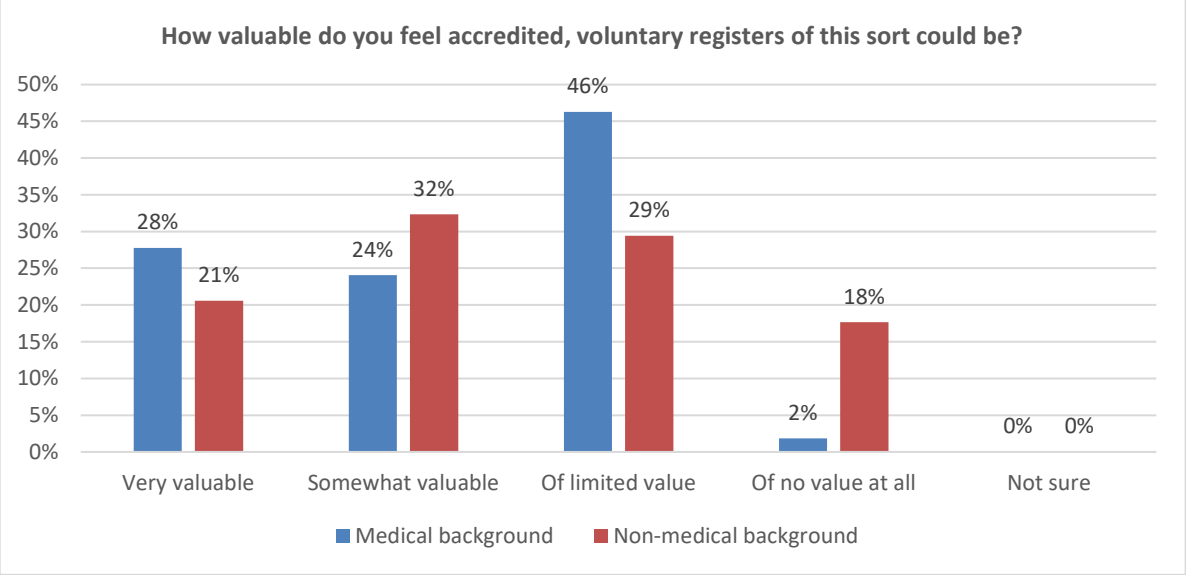
4.2 Overall, 64% of respondents said that it could be effective; 25% thought it couldn't; and the remaining 11% didn't know or weren't sure.

4.3 The graph below shows how different stakeholder groups responded.



4.4 Although most of the current Accredited Registers thought a voluntary system of registration could be effective in protecting the public, 41% of practitioners disagreed, with the majority stating that the voluntary nature undermines the programme, suggesting that certain occupations such as psychotherapy or sonography should be regulated. Registers not accredited by us also tended to disagree. Reasons given included the lack of recognition of the current programme by the healthcare system and lack of awareness of the programme by service users meant that the programme was not currently effective in protecting the public.

4.5 The Patients Association asked the 105 members it surveyed how valuable they felt accredited, voluntary registers of this sort could be. The graph below shows the responses.



4.6 A common theme amongst survey respondents and those who attended our stakeholder events who didn't think that a voluntary system could be effective was that it cannot protect the public enough because it is not mandatory. There is not enough use and recognition of the programme by employers currently to overcome this.

> *"A number of employers were not aware of the PSA and accredited registers and as such were not using the registers for their employees.*" (NHS Employers)

4.7 Some responses indicated that the assurance the programme offers could be beneficial in supporting broader workforce aims, such as for the roles set out to expand or be introduced as part of the NHS Long-Term Plan for England.

> "Multi-disciplinary teams (MDTs) play an increasing role in the delivery of healthcare within the UK. These roles are not subject to statutory regulation yet work closely alongside regulated professionals and often have direct contact with vulnerable patients who will have a wide variety of mental and/or physical conditions. Assurance of these new roles is therefore essential for employers, patients and the public to have confidence in the services they deliver and will enable effective team working by ensuring there is an 'umbrella' of assurance for all roles."
> *Personalised Care Group, NHS England /Improvement*

4.8 Amongst those who though that a voluntary system could be effective, it was still important to recognise limitations. Some respondents recognised the value of having the programme but stated that statutory regulation remained the ideal goal.

4.9 Across all responses and stakeholder groups, a number of respondents thought that the programme had potential to be confusing for the public. Without effective ways to ensure that those accredited are meeting standards, the benefits might be outweighed by the costs. Some respondents felt this was particularly important for those seeking services from complementary and alternative practitioners.

"A balance has to be struck between potential gains and the possibility of unintended negative consequences." (Practitioner)

The scope of the programme

4.10 Respondents were asked how they think the Authority should determine which occupations should be included within the programme, and whether there is anything further they would like us to consider in relation to assessing applications for new registers.

4.11 This was presented as an open question. The main areas suggested for us to consider in determining which registers and roles would be eligible for the programme were the risk of the role, patient choice, and level of competence and training.

4.12 In terms of risk, some respondents thought that professions which have direct contact in providing services to the public and patients, and which would usually be subject to an enhanced DBS check by an employer, should be included.

"Right-touch regulation appears to be a good place to start." (Accredited Register)

4.13 Patient choice – some thought that any service which is chosen by the public because they perceive it gives some benefit should be considered.

4.14 Several respondents thought that eligibility should be linked to education and training standards. Occupations that have a National Occupational Standards of training was suggested by two respondents. Others thought that accreditation should be reserved for registers which required the highest standards of education and training in their field. Several respondents thought that the programme should have clearer thresholds for standards being met.

"The scheme should be reformed to have a higher threshold for accrediting voluntary registers for roles or professions which deliver NHS services and patient facing care". (Health Education England)

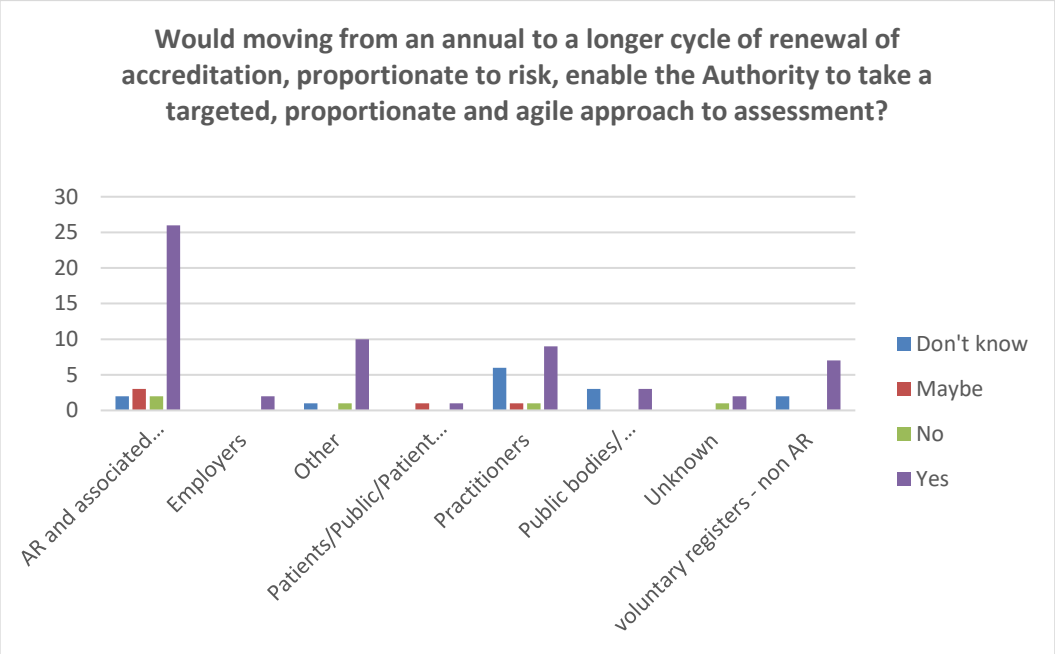
4.15 Some respondents related their response to the wider regulatory system, such as having a single regulatory system for all healthcare professions. We received some comments about the way the programme itself was structured, with respondents noting that organisations that accredit more than one role and 'umbrella organisations' should be discouraged so that accreditation for each role can be individually assessed.

Assessment cycle

4.16 Our consultation survey asked whether moving from an annual to a longer cycle of renewal of accreditation, proportionate to risk, will enable us to take a targeted, proportionate and agile approach to assessment.

4.17 71% of all respondents agreed that we should move to a longer assessment cycle. Only 6% said no, and the remaining 23% were unsure.

4.18 The graph below shows how different stakeholders responded.



4.19 Respondents who supported these proposals, and provided comments, saw the benefits as being of reduced bureaucracy. Some suggested that the time saved could be used to raise awareness of the programme, and to help ensure that organisations newer to the programme are supported.

> *"This will free up time for other priorities such as raising awareness of the register and communications with registrants. The PSA should retain the ability to conduct out of cycle reviews if serious concerns are raised."* (Accredited Register)

4.20 As part of our proposals, we suggested that clearer minimum standards could be introduced for registers. The majority of respondents who commented on this aspect of the proposals said that the requirements were reasonable and would support registers to maintain standards. Some felt that the minimum standards would be helpful in encouraging new registers to apply.

> *"Specific minimum requirements are imperative for education and training in order to achieve transparency for the public to be aware of level of competencies as well as providing a higher protection to the public."* (Practitioner)

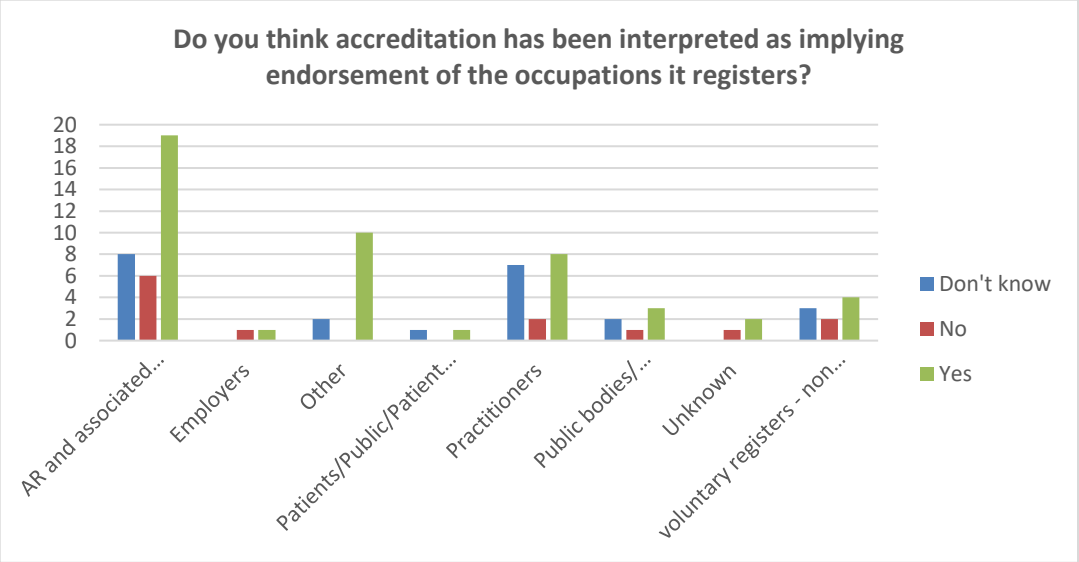
Is accreditation understood as an endorsement of the occupation it registers?

4.21 Our survey asked whether accreditation has been interpreted as implying endorsement of the occupations it registers. Respondents were asked to

comment on whether if so, they thought this was problematic, and how it might be mitigated for the future.

4.22 Across all respondents, 57% agreed that accreditation did imply endorsement of the occupations registered. 16% said no, and the remaining 27% weren't sure.

4.23 The graph below shows how different stakeholders responded.



4.24 Practitioners and voluntary registers that weren't accredited by us had the highest proportions answering 'no'. Comments from those who didn't think that accreditation implied endorsements were varied. Some thought that this could only be achieved by statutory regulation. Others thought that accreditation would denote a level of competence by a practitioner or of meeting our Standards, but not endorsement of the occupation itself.

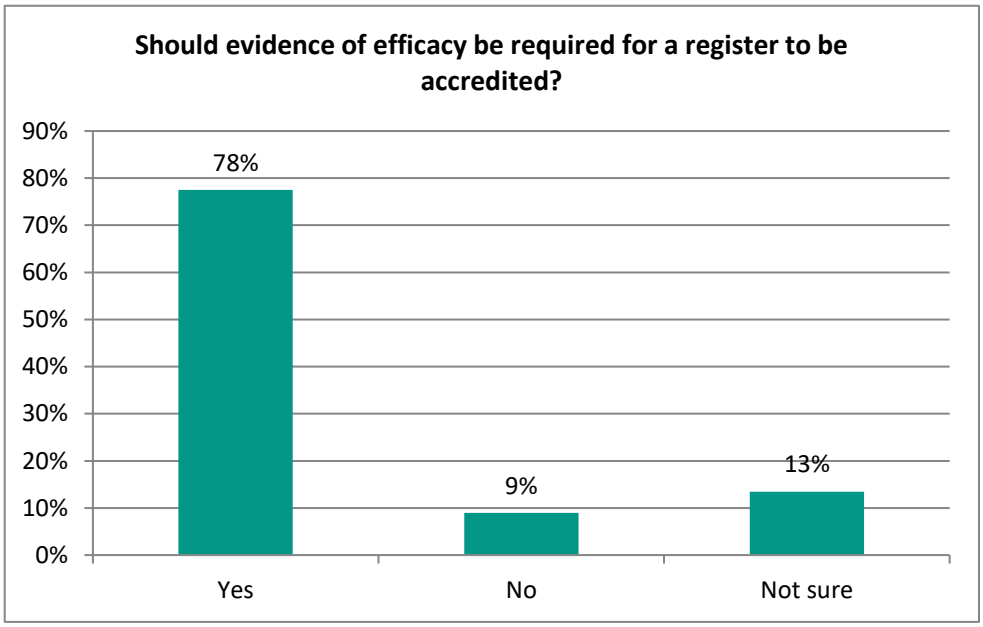
4.25 Current Accredited Registers, patients and the public, and employers generally did think that accreditation implied endorsement. Some of the comments provided suggested that this could cause harm if there was not evidence of effectiveness, particularly for those who may be physically, emotionally and/or financially vulnerable.

> *"Employers did think that it implied endorsement, and that this could be problematic if the occupation had a controversial or absent evidence base or objective utility".* (NHS Employers)

> *"If such people put their faith in 'alternative' forms of treatment they may be deterred from seeking help from mainstream medicine and are clearly at risk of being harmed as a result."* (Healthwatch UK)

> *"The public should be informed as to whether accreditation confers endorsement of the effectiveness of the therapy. If not, the rationale for providing accreditation to the voluntary register needs to be clearly articulated to the public."* (NHS Education for Scotland)

4.26 The Patients Association asked its members whether evidence of efficacy should be required for a register to be accredited. It told us 'there was a very strong balance of opinion among our survey respondents for evidence of efficacy being made a requirement for accreditation.' The results for the 105 respondents are below.



4.27 Many responses recognised that the factors likely to imply endorsement are multifaceted and not restricted to evidence about effectiveness. Some respondents offered suggestions for how the risks stemming from being seen to confer endorsement could be mitigated. Some suggested a requirement for an evidence base, whilst others thought this could be overcome by clearer communication.

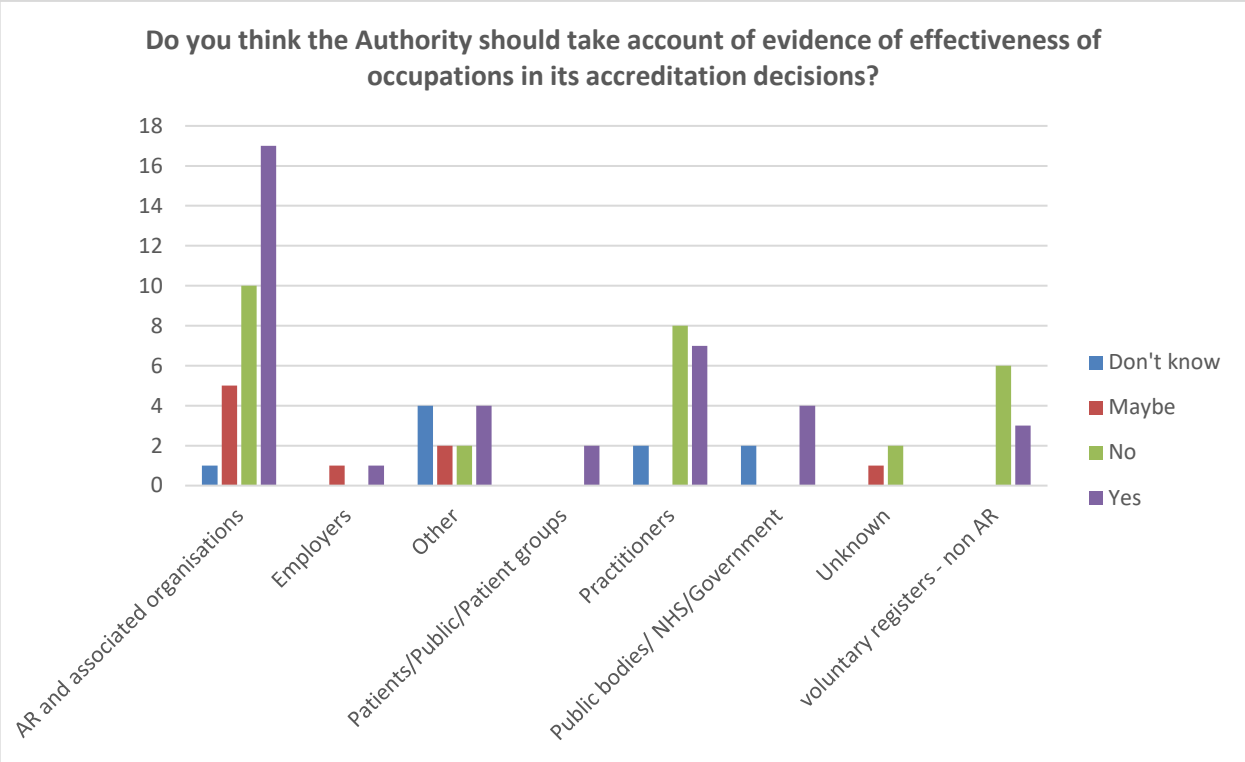
> *"There was a theme among responses relating to the behaviour of the practitioner and information provided to patients: practitioners being clear about the evidential status of their discipline, or not dissuading patients from seeking conventional medical help, might be useful requirements, short of full evidence of efficacy."* (The Patients Association)

Evidence of effectiveness and decisions about accreditation

4.28 Respondents were asked whether they thought that we should take account of the effectiveness of occupations in our accreditation decisions.

4.29 Overall, 45% of respondents thought that we should take account of the effectiveness of occupations. 33% thought we shouldn't, and the remaining 22% weren't sure.

4.30 The graph below shows how different stakeholders responded.



4.31 Comments from respondents who didn't think that we should consider evidence of efficacy in our accreditation decisions mostly focused on practical challenges associated with measuring effectiveness, and views that it is not our role to consider efficacy.

> *"Many therapies are configured in such a way that their effectiveness does not lend itself to evidence-based research. This is not reflective of their effectiveness, but due to the unique nature of the therapy. Many clients are referred by family and friends, and for them, it is the endorsement of a trusted friend or family member that matters and works for them, rather than whether the therapist is a registrant on an accredited register."* (British Complementary Medicine Association)

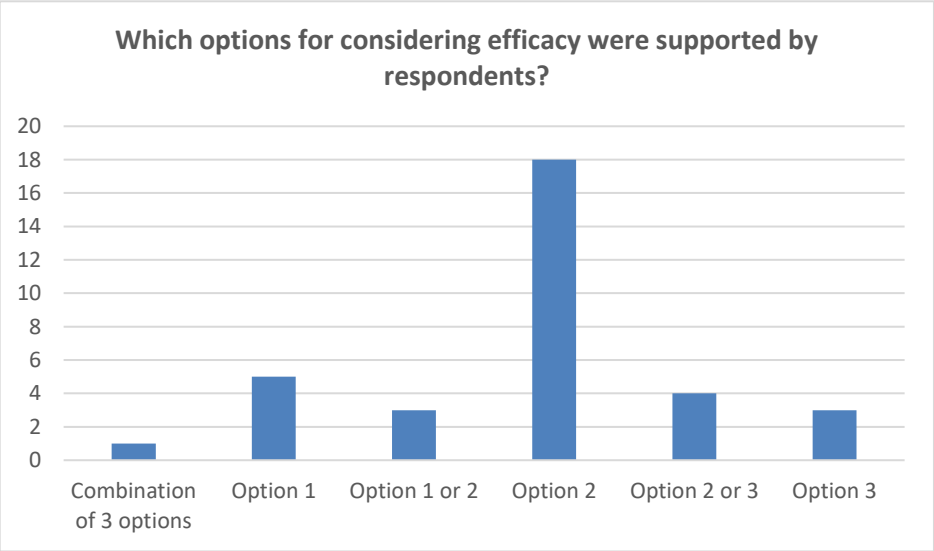
4.32 Our consultation set out three options for considering efficacy:

1) A requirement for the register to have developed a knowledge base for the occupation registered, similar to our current approach (Standard 6)

2) A requirement for the register to have a minimum acceptable evidence base

3) A requirement for the register to ensure there is alignment of the practice of its registrants with external guidance such as NICE and its equivalents.

4.33 34 respondents expressed a preference about these options, as set out in the chart below.



4.34 These results show broad support for introducing a minimum evidence base. However, comments from those who supported this option recognised the challenges of doing this. Some commented that it is an intervention, rather than an occupation, that can be evidenced.

4.35 The public bodies who responded to our consultation generally favoured Option 3. However, many highlighted that NICE and equivalent guidance does not cover every aspect of care. It would therefore be important to consider how registers of roles working within varied settings, including education and social care, would be able to demonstrate any new requirements.

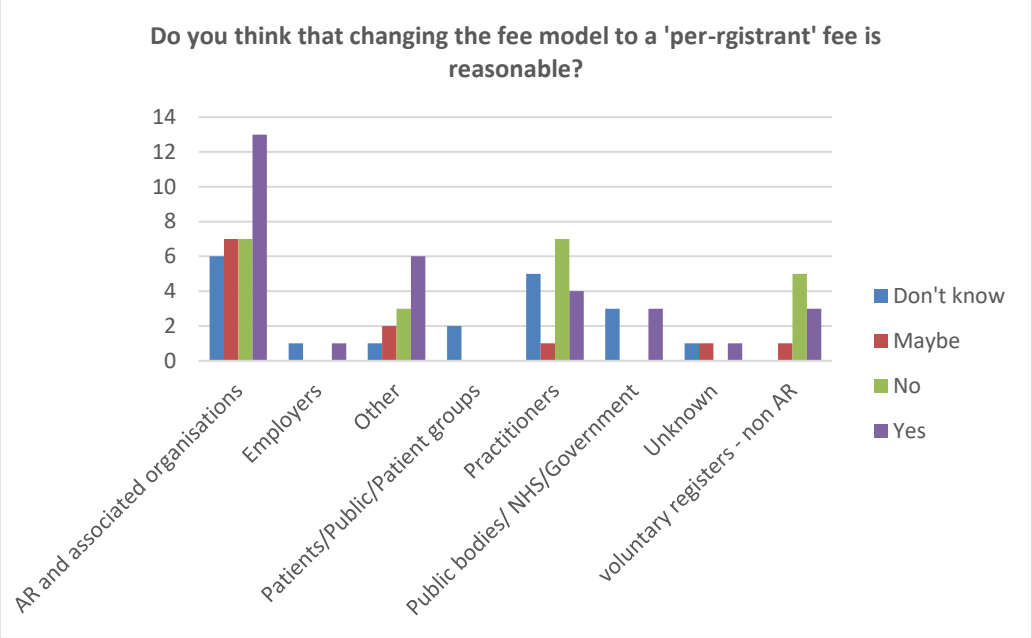
> *'The PSA should avoid creating or maintaining registers that appear to endorse harmful treatments or treatments proven not to work. Registrants should be required to practice in accordance with evidence-based practice principles at all times, which require the artful integration of research evidence, patient choice, and clinician expertise.'* (Health Education England)

Funding

4.36 Registrants were asked whether they thought that changing the funding model to a 'per-registrant' fee is reasonable, and whether there were any other models you would like us to consider.

4.37 Overall, 37% of respondents agreed our proposals were reasonable. 26% disagreed, and the remaining 37% weren't sure.

4.38 The table below shows how different stakeholders responded to this question.



4.39 Amongst those who provided comments to this question, regardless of whether respondents agreed with our proposals, affordability for registrants and registers was a key consideration. Many felt that the fee should be kept as low as possible, so that it does not discourage prospective registrants or registers from joining. Some commented that they thought it was the responsibility for UK Government to fund protection of the public.

4.40 The current Accredited Registers were broadly split between agreeing, disagreeing and being unsure about our proposals. Some noted that the current

> *"This fee will need to be charged directly back to the individual registrant by the various regulators as most organisations are very unlikely to be in the position to carry the burden of increase."* Accredited Register

fees are already a substantial investment, and that some organisations will have been affected by the Covid-19 pandemic. Amongst this group, the concerns of those who disagreed with our proposals were mainly due to the impact of the increases in fees to organisations with larger registrant numbers. Some organisations expressed concern about the timing of the increase in fees and highlighted the need to consult with their members on the change since they considered it would need to be passed on to registrants through increases to membership fees.

4.41 Several of the Accredited Registers suggested that we could take an alternative 'tiering' approach, with fees set according to whether an organisation was categorised as 'small', 'medium' or 'large' according to registrant numbers. Having a minimum payment, and a cap for larger registers, was also suggested.

4.42 Across all stakeholder groups, reasons given from those who supported our changes including being more affordable to smaller registers, which would allow the programme to expand its coverage. However, several respondents thought it would be important for us to be able to demonstrate the value of the programme to registrants.

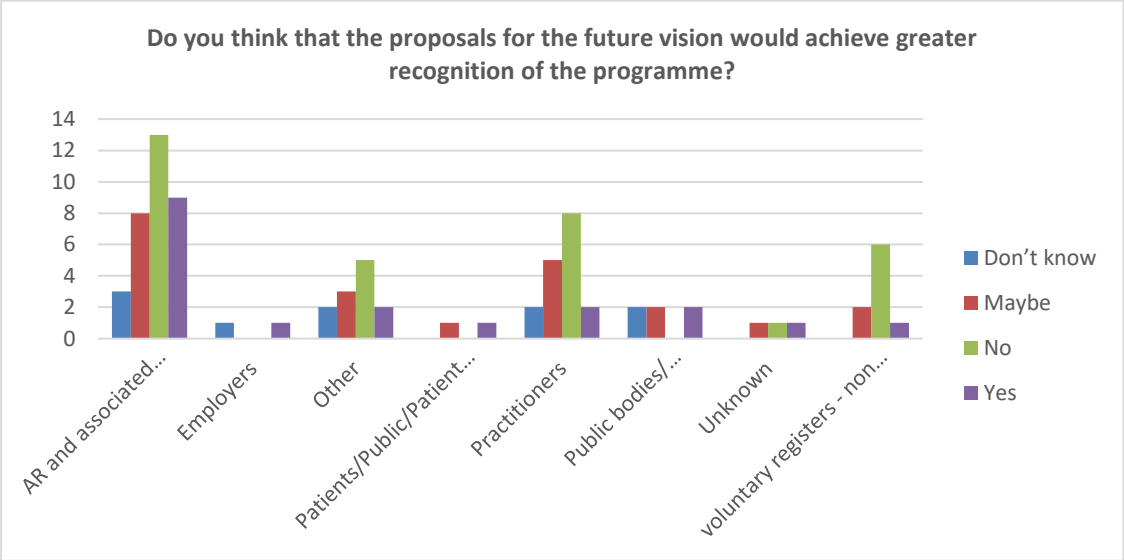
> *"A per-registrant model will allow many more professions to be looking at applying for registration without having to compromise by joining other associations."* Accredited Register

Our vision for the future

4.43 Respondents to our survey were asked whether our proposals for the future vision would achieve greater use and recognition of the programme by patients, the public, and employers.

4.44 Overall, 23% agreed that our proposals for the future could achieve this. 39% disagreed, and the remaining 38% weren't sure.

4.45 The graph below shows how different stakeholders responded to this question.



4.46 The comments from those who were unsure about the future vision tended to support the overarching principles but raise questions about how they would be achieved in practice. The wide variety of the types of roles registered was frequently mentioned. Within the occupations themselves, some questioned whether consistent education and training standards could be achieved, due to the variety and complexity of curricula currently used.

4.47 For many of those who disagreed, comments referred to the wider regulatory system. Some highlighted the need for a clearer pathway to statutory regulation. One respondent suggested that we should secure agreement on the programme from each of the four nations, so that Accredited Registers can act as part of the multi-layered regulatory system.

> *"We support stratification of occupations according to risk but would want to see this across statutory and non-statutory registers."* (Public Health England)

4.48 Some comments suggested that consideration of standards of education and training are a more significant factor in gaining credibility for employers than changes to the regulatory architecture. Many comments highlighted the importance of work to raise awareness of the role of accreditation as being key to future effectiveness.

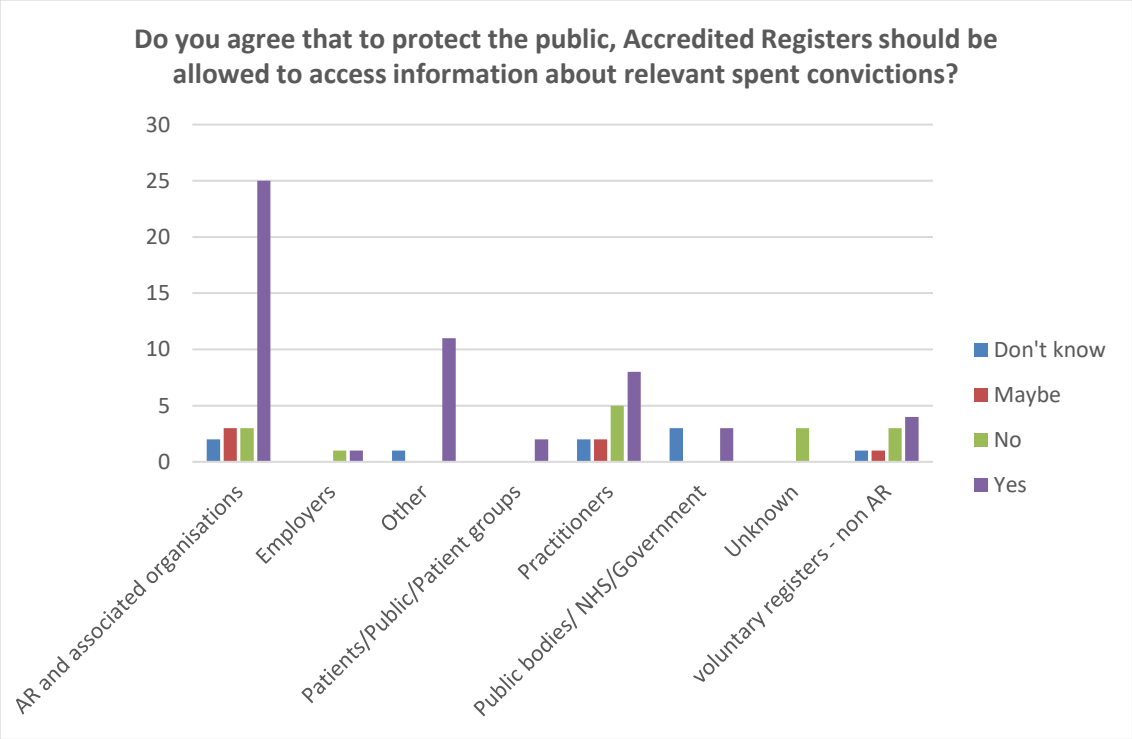
Safeguarding

4.49 Respondents were asked whether to protect the public, the Accredited Registers should be allowed to access information about relevant spent convictions.

> *"The changes proposed in the strategic review and alignment with key NHS priorities and occupations should ensure greater use and recognition, system wide…the PSA must also consider the impact of Government's review into UK regulation, due to begin 2021."* (Health Education England)

4.50 Overall, 64% of respondents agreed with this statement. 18% disagreed, and the remaining 18% weren't sure.

4.51 The graph below shows how different stakeholder groups responded to this question.



4.52 There was strong support across all groups to this question. Respondents who left comments for this question generally thought that this was important to protect the public. Some comments indicated it should be considered as an essential part of the assurance that the programme provides.

> *"On balance…yes. There are obvious examples of where you may not want individuals working with the general public or children based on past convictions."* Sports Massage Association

4.53 The comments from those who weren't sure and who disagreed that Accredited Registers should have access to information about relevant spent convictions focused mainly on questions of whether this should be within the organisation's remit. Many of these respondents who commented were concerned about the privacy and legal implications of registers holding this type of information.

Equalities impacts

4.54 Respondents were asked whether there were any aspects of these proposals that they felt could result in differential treatment of, or impact on, groups of individuals with characteristics protected by the Equality Act 2010.

> *"Many groups with protected characteristics that fall under the Equality Act 2010 practise and require access to forms of traditional medicine that may be impacted by the decision to remove certain occupations from the register."* The Association of Naturopathic Practitioners

4.55 Several respondents raised concerns that our proposals could aggravate inequalities and tensions that they saw as inherent in having two layers of regulation, with some being required to be registered by law.

4.56 Several comments were specific to the psychological professions. For example, one respondent commented that our proposals in regard to greater consistency of standards for education and training could make it more difficult to undertake 'radical experiments' that might mitigate disadvantages and open up the field of counselling and psychotherapy. Some commented that women might be more likely to train as counsellors, and that this might result in the fee increases being disproportionately passed down to women.

4.57 Some comments highlighted that users of some services offered by Accredited Registers might be more likely to be older or have long-term conditions. Changes to how we consider evidence of efficacy, which might affect eligibility of some current and prospective organisations for accreditation, could remove the assurances for these patients.

> *"Some protected groups (e.g. elderly, cancer patients) are more frequent users of particular voluntary registered healthcare professions. If the PSA removes the ability of these professions to be accredited, protected groups may have no choice but to choose between practitioners who are not accredited or protected through the PSA process."* (Homeopathy UK)

> *"It needs to be considered that patients often engage with non-NHS services because they offer support not generally offered within the NHS. As this can be in sectors such as hospice care or specialist charities, this may have a detrimental effect on the care of children, older patients and those with a disability."* (Keech Hospice Care)

4.58 Some comments indicated that our proposals could have a positive impact on individuals with characteristics protected by the Equality Act 2010, by being clear about practices that may be harmful and/or discriminatory, such as conversion therapy and Complete Elimination of Autistic Spectrum Expression (CEASE)

which may sometimes be associated by some organisations currently eligible for accreditation.

5. Next steps

5.1 We are using these findings to develop our proposals further. This includes using the finding of Question 9 to identify the specific groups with whom we need to seek to engage with to enhance our understanding of the potential impacts of our proposals.

5.2 Our Board considered the initial analysis of the consultation in March 2021. It will consider our revised proposals in May 2021. We will publish further detail after this point, with our Equalities Impact Assessment. We anticipate that our proposals will be implemented in July 2021.

6. Annex A – Stakeholder engagement events

6.1 A range of stakeholders were invited to round table style events to share their views on specific aspects of the programme. With their permission, outputs from the groups were added to the final consultation responses.

6.2 On 3 December, we met with colleagues from the UK Governments, NHSE/I, Health Education England, NHS Employers and Public Health England.

6.3 On 9 December, we met with all current Accredited Registers.

6.4 On 27 January, we met with the following organisations to discuss the patient perspective:

- Department for Health and Social Care
- Welsh Government
- Scottish Government
- Board of Community Health Councils (Wales)
- Patients Association
- Hospice UK

6.5 On 28 January, we met with the following organisations to discuss the employer perspective:

- Department for Health and Social Care
- Welsh Government
- Scottish Government
- Health Education England
- NHS Employers
- NHS Professionals
- Royal College of General Practitioners
- Independent Healthcare Providers Network

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