Professional bodies' questionnaires

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Introduction

At its meeting on 12th October 2005, the PLG approved a questionnaire to be sent to the professional bodies asking for their input.

Following the group's work, the professional bodies were also provided with the summary and profession-specific sections of the paper analysing the response from registration assessors (considered by the PLG on 24th January 2006). The bodies were not directly provided with the conclusion sector of that paper.

The profession bodies were also encouraged to comment on any other matters regarding the standards that they considered to be relevant.

Responses were received from 12 professional bodies. The following organisations responded with their feedback:

(i) Association of Clinical Scientists (ACS)
(ii) Association of Operating Department Practitioners (AODP)
(iii) British Association of Art Therapists (BAAT)
(iv) British Association of Dramatherapists (BADT)
(v) British Association of Prosthetists and Orthotists (BAPO)
(vi) British and Irish Orthoptic Society (BIOS)
(vii) British Chiropody and Podiatry Association (BCPA)
(viii) British Dietetic Association (BDA)
(ix) British Paramedic Association (BPA)
(x) Chartered Society of Physiotherapy (CSP)
(xi) College of Occupational Therapists COT)
(xii) Institute of Biomedical Science (IBMS)
(xiii) Institute of Chiropodists and Podiatrists (ICP)
(xiv) Royal College of Speech and Language Therapists (RCSLT)
(xv) Society of Chiropodists and Podiatrists (SCP)
(xvi) Society and College of Radiographers (SOR)

Throughout this paper we refer to the professional bodies by the initials given above.

This paper will being with a general summary of the feedback received and will then consider the feedback received in relation to two specific topics: fitness to practise and autonomy and accountability. These were identified from the registration assessors' feedback.

The response from each professional body will then be considered. Where additional or changed wording has been suggested to a particular standard, this is indicated by bold, underlined type in the text.

Where this might be helpful to the PLG a commentary has been included (in shaded boxes) highlighting the factors that might be taken into account when considering the suggestions made and drawing attention to areas of the existing standards.

Summary

Most of the professional bodies who responded broadly agreed that the existing generic and detailed generic standards continue to be relevant and applicable. In keeping with the registration assessors' feedback, the professional bodies suggested a small number of changes to the generic standards for the purposes of clarity and accuracy.

Some of the professional bodies, such as the Society and College of Radiographers, suggested revisions of or additions to the profession-specific standards to:

(i) reflect standard or accepted practice or changes in the scope of the profession;

(ii) reflect the standard content of undergraduate curricula; and

(iii) take account of changes in/ current use of terminology.

The Chartered Society of Physiotherapy suggested revisions to the generic and profession-specific standards. They raised a number of concerns (amongst others) about the status, purpose and style of the standards.

A number of the professional bodies commented on the suggestions made by the registration assessors.

The introduction

A small number of comments were received about the introduction to the standards of proficiency.

The Chartered Society of Physiotherapy raised a number of problems with the existing introduction which included:

(i) lack of clarity and contradiction in the introduction about 'scope of practice';

(ii) explicit explanation needed about the relationship between the standards and the Standards of conduct, performance and ethics and CPD standards; the relationship between the standards and the Knowledge and Skills Framework (KSF); and

(iii) the examples given in the introduction are ‘clumsy and inaccurate’.

The RCSLT and BPA similarly felt that ideas around scope of practice could be made clearer. The BPA requested that more detail was needed about the student perspective and the importance of recognising the limitations of your scope of practice as a new student and new registrant.

Fitness to practise

This was a key theme from the registration assessors' questionnaires. The existing standards read:

1a.7 understand the obligation to maintain fitness to practise
- *understand the importance of caring for themselves, including their health*

1a.8 understand the need for career-long self-directed learning.

In summary the registration assessors noted that fitness to practise had numerous connotations and that this was minimised by reference solely to health. The link between fitness to practise and learning was also recognised.

The conclusion to the paper considered by the PLG on 24th January 2006 [appended at appendix 1] suggested the following standard in light of the feedback received:

***Standard 1a.7**:*

1a.7 - understand the obligation to maintain fitness to practise

- *understand the need to practise safely and effectively within their scope of practice*
- *understand the importance of maintaining health and care for themselves*
- *understand the need to keep skills and knowledge up to date and the importance of career-long self-directed learning*

Consideration could then be given to removing standard 1a.8 could in light of this amendment.

There were a number of comments and suggestions about this standard which were broadly in agreement with the comments made by the registration assessors. In particular:

(i) many noted that the term could be confused with 'physical fitness';

(ii) recognised that the term encompassed a broad range of professional responsibilities; and

(iii) linked fitness to practise with continuing professional development and learning.

The following changes were suggested:

(i) Both the AODP and COT suggested that we could amend the standard to include both physical and mental health. The AODP suggested the addition of the words 'physical' and 'psychological'. The COT suggested that standard could read:

'understand the importance of caring for themselves, including their physical and mental health'

They also noted that one respondent suggested an additional standard about 'ensuring a registrant's responsibility to inform their employer of special needs to support their employment'.

(ii) The SOR suggested that the new standard should read:

'*understand the obligation to maintain fitness to practise* ***and to take responsibility for self-reporting health, disability or conduct matters where this might impact on their practice*****'.**

The group may wish to consider whether the suggested amendment relates more to ongoing and continuing fitness to practise and is therefore not appropriate for an entry-level standard. The requirement that registrants must inform the Council of any important information about their conduct or health is included in the standards of conduct, performance and ethics at paragraph 4.

(iii) Both the BIOS and ICP agreed that we could consider merging 1a.7 and 1a.8 together. The BIOS suggested that the standard could read:

'*understand the obligation to maintain fitness to practise* ***through*** *career-long self directed learning and* ***update CPD in line with the requirements of the professional body and the HPC and KSF'***.

There are a number of frameworks which complement the standards. The group may therefore wish to consider whether specific reference to the KSF is necessary. In addition, some registrants are not members of a professional body.

It is submitted that CPD and learning are just one facet of what is meant by 'fitness to practise' and that the group would not wish to limit the meaning of the term'.

The ICP agreed with the suggestion that we might consider merging the standards but felt that it was still important that we made reference to maintaining health.

(iv) The IBMS considered the suggested change to existing standard included in the registration assessors' paper and said that they supported the amendment in full.

'Fitness to practise' is a term established in Part V of the Health Professions Order 2001. It is also referred to in a number of HPC publications.

The publication 'What happens if a complaint is made about me?' defines fitness to practise in the following terms:

'When we say that you are fit to practise we mean that you have the health and character as well as the necessary skills and knowledge to do your job safely and effectively. We also mean that we trust you to act legally.'

Professional autonomy and accountability

A number of registration assessors felt that it was important to add to the standards to explicitly refer to autonomous practice. The existing standards read:

1a.5: know the limits of their practice and when to seek advice

- *be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem*
- *be able to initiate resolution of problems and be able to exercise personal initative*

1b.1: know the professional and personal scope of their practice and be able to make referrals

The conclusion to the paper considered by the PLG on 24th January 2006 [appended at appendix 1] suggested the following standard in light of the feedback received:

1a.5: be able to practise as an autonomous professional, exercising their own professional judgement

- *be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem*
- *be able to initiate resolution of problems and be able to exercise personal initiative*
- *know the limits of their practice and when to seek advice or refer to another professional*

- *recognise that they are personally responsible for and must be able to justify their decisions*

Consideration could then be given to removing standard 1b.1 in light of these amendments.

There were a small number of comments and suggestions about this area. The BADT felt that the standards should include reference to arts therapists as autonomous practitioners who have 'the ability to make independent clinical decisions'. The Institute of Chiropodists similarly agreed and the CSP felt there should be more emphasis on autonomy throughout the standards.

The IBMS considered the suggestion made in the registration assessors' paper and agreed with the amendment in full. The BIOS suggested that that we might amend standard 1a.1 to read:

'[be able] to practice as an autonomous practitioner within the legal and ethical boundaries of their profession'.

The AODP, however, felt that autonomy was adequately dealt with by the existing standards 1a.1 and 1a.5.

Arts Therapists

British Association of Dramatherapists

The response from the British Association of Dramatherapists was put together following consultation with members of their Executive Committee and from feedback from full members of BADT.

The following comments and suggestions were made:

(i) No generic standards were felt to be redundant or not applicable to a particular profession

(ii) In agreement with the comments made by a registration assessor, a new profession-specific standard within 3a.4 to cover clinical supervision was suggested:

'understand the need for and maintain regular sessions of clinical supervision with an appropriately qualified clinical supervisor'

The group may wish to consider:

(i) whether this is a necessary, threshold entry standard rather than best or good practice;

(ii) whether ideas surrounding reflection and review of practice are already encapsulated in 2c: 'critical evaluation of the impact of, or response to, the registrant's actions';

(iii) the potential difficulties and ambiguity of specifying 'an appropriately qualified clinical supervisor'.

(iii) They also agreed with the suggestion by a registration assessor of 'remodelling' standard 3a (knowledge, understanding, skills). They said; 'The Art Therapists only section could be reframed to include the other arts therapists'.

British Association of Art Therapists

The response from BAAT took into account the views of members and the views expressed by the original working group set up to look at the Arts Therapists' standards.

The following comments and suggestions were made:

(i) The generic and detailed generic standards are relevant and sufficiently clear;

(ii) There should be a standard or statement about supervision in line with the comments expressed above and by the registration assessors.

(iii) The group's attention is drawn to the Arts Therapists part of the HPC website and the information given about supervision. This presently reads:

'Supervision
When we refer to 'supervision', it refers to the process of an accountable, autonomous practitioner overseeing the work of someone who is normally either an assistant practitioner, a student, or a health professional who is learning new skills.
However, within art therapy, the term 'supervision' is used in a different context, to mean a process where the art therapy process and the relationship with the client is supervised by another practitioner. Within art therapy, the term 'supervision' does not infer that the person being supervised is not autonomous, or that they are learning, but is instead viewed by the professional body as a regular part of art therapists' practice.'

Biomedical Scientists

Institute of Biomedical Scientists

The IBMS were generally positive and supportive of the existing standards, concluding: 'As the standards have become more familiar and the certificate of competence interprets them appropriate to biomedical science practice, I have opted (in general) for little change.'

It was felt that the standards were applicable to biomedical science practice although in places it was felt that the terminology reflects 'a bias towards professions with direct patient contact'. The profession-specific standards were largely felt appropriate because they: '…represent the breadth of biomedical science and therefore the scope of practice for biomedical scientists, rather than discipline specific practice.'

The following suggestions were made:

(i) 1a.6 (effective management of workload) might be clarified by adding a profession-specific standard:

'be able to work effectively and efficiently within the laboratory team'

However, it is noted that this would duplicate standard 1b.3

The existing standard 1b.3 reads:

be able to contribute effectively to work undertaken as part of a multi-disciplinary team

(ii) 1b.2 (professional relationships). It was felt that the following standard focused on direct patient interaction:

'understand the need to engage patients, clients and users in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals'

It was suggested that this could read instead: '… *in planning and evaluating care,* ***or in the provision of investigative services***'.

(iii) 2a.3 (undertake/ arrange clinical investigations). It was felt that the standard might read:

'[be able to] undertake clinical **or scientific** *investigations as appropriate'*

(iv) 3.a1 (knowledge, understand skills). The following changes were proposed:

The existing standards (professions-specific) read:

- *understand the role of cellular pathology in the diagnosis and treatment of disease*
- *understand the role of cellular pathology in the diagnosis and treatment of disease*
- *understand the role of medical microbiology in the diagnosis and treatment disease*
- *understand the role of clinical biochemistry in the diagnosis and treatment of disease*

The suggestion was that these standards could be conflated to read:

'- understand the role of the following in the diagnosis and treatment of disease: cellular pathology; clinical biochemistry; clinical haematology; clinical immunology' medical microbiology'

Chiropodists and Podiatrists

Society of Chiropodists and Podiatrists

The response from the SCP was complied following consultation with members.

The following suggestions were made:

(i) 2b.4 (profession-specific, administration of local anaesthesia and prescription-only medicines). The Society said: 'As all applicants to the register from pre-registration courses approved by the HPC are certified in the use of local analgesia and prescription-only medicines, we feel it is now necessary for these standards to remain optional.'

The existing standards read at 2b.4 (profession-specific):

be able to…

- administer relevant prescription –only medicines, interpret any relevant pharmacological history and recognise potential consequences for patient treatment. This standard applies only to registrants who wish to be certified as competent under the Medicines Act 1968 by the HPC.

- apply local anaesthesia techniques. This standard applies only to registrants wish to be certified as competence under the Medicines Act 1968 by the HPC

At present, the two standards relating to the administration of prescription-only medicines (POMs) and local anaesthetics (LA) are optional. The consequences of this are that education providers could choose to offer a course to a student which did not include these areas and would not jeopardise the approved status of their course; and a course could be approved for the purposes of registration without including POMS or LA as course components.

The consequences of removing the 'optional' part of these standards is that only programmes which included these components could be approved for registration purposes. This executive is seeking legal advice in this area and will report the outcome of this at the next meeting of the group.

(ii) It was suggested that the following should be added to standard 2b.4:

'be able to place an unconscious patient in the recovery position and carry out any other relevant moving and handling techniques in the event of medical emergency'

The group will wish to consider whether this is a necessary competence standard for the practice of the chiropody profession (i.e: it is an integral part of what makes someone a chiropodist or podiatrist). The group should consider whether someone could practise safely and effectively as a chiropodist without this standard.

It is submitted that whilst first aid training may be desirable for all health professionals, this may not be a standard which is necessary or profession-specific to chiropody and podiatry.

(iii) It was suggested that standard 3a.3, which covers the need to establish and maintain a safe practice environment should be supplemented to make it clearer that compliance with the law is required, not simply understanding. It was suggested that standard 3a.3 (generic) might read:

'understand the need to establish and maintain a safe practice ***environment and comply with the Health and Safety and Work Act 1974 with particular reference to Controlled Waste and Control of Substances Hazardous to Health (COSHH) Regulations'.***

It was suggested that this could be added as a profession-specific standard under 2b.4, if not appropriate for all professions.

The group may wish to consider whether the existing standard 3a.3 encapsulates the need to comply with legislation such as the Health and Safety Act. The standard reads:

- be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these

It is submitted that the existing standard is suitably generic to be applicable to all professions and to take into account changes in legislation and best practice.

Institute of Chiropodists and Podiatrists

The response from ICP was put together following discussion at Executive Committee level. They concluded that the standards were 'fair and comprehensive' save a small number of suggested amendments.

The following comments and suggestions were made:

(i) 2b.4 (profession-specific) currently reads:

'Carry out surgical procedures for skin and nail conditions'

The Institute said that '...it needs to be made clear here also, that this can only be performed by those practitioners with advanced training and suitable facilities'.

(ii) 2b.4 (profession-specific) covers ensuring that patients are immobilised for effective interventions. It was suggested by a registration assessor that this could be removed. The Institute disagreed, saying that they felt that this was a necessary standard.

(iii) The Institute agreed with the suggestion by a registration assessor that there might be an additional profession-specific standard to cover 'topical dermatological therapeutics and management and dressing of foot ulceration'.

British Association of Chiropody and Podiatry

The response from the BPA was put together follow discussion by three branch chairman.

The BCPA concluded that everything had been covered in the existing standards. They did not feel that any standards were redundant or that any additional standards were needed.

They commented on the suggestion that we should remove the 'optional' part of the standard relating to LA and POMs, noting that many of their members who are registrants do not hold certificates of competence. They said: 'This we would resist this for a whole number of good reasons'.

Clinical Scientists

Association of Clinical scientists

The response of the ACS was put together following discussion by the board of ACS.

The following suggestions were made:

(i) 1a.8 (career-long self-directed learning). It was suggested that the following profession-specific standard should be added:

'maintain an awareness of new methods of diagnostic and therapeutic practice'

The group may wish to consider whether the idea of keeping up to date with new developments is encapsulated in standards 1a.8, 2b.2 and 2c.2:

be able to draw on appropriate knowledge and skills in order to make professional judgements

- be able to change their practice as needed to take account of new developments (2b.2, generic)

- recognise the need to be aware of emerging technologies and new developments (2c.2 profession-specific)

(ii) It was suggested that profession-specific standard 1b.2 should be deleted. It presently reads:

'be able to respond to enquiries regarding the service they provide when dealing with clinical colleagues'

(iii) 1b.4 (communication skills). The following profession-specific standard is suggested:

'be able to present the outcome of research and development activity in peer reviewed journals and at scientific meetings'

The group may wish to consider whether this is a necessary competence standard and whether this is adequately encompassed by the following existing standards:

1b.4 (generic):

be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, users, their relatives and carers

1b.5 (profession-specific):

- be able to communicate the outcome of problem solving and research and development activities

- be able to summarise and present complex scientific ideas in an appropriate form

2b.1 (profession-specific):

- be able to present data and a critical appraisal of it to peers in an appropriate form

(iv) 2b.1 (research, reasoning, problem-solving). The following profession-specific standard is suggested:

'be able to advise practice development based upon research findings'

(v) 2b.5 (record keeping). Add profession-specific standard:

'be able to critically apprise the safety, security and legal aspects of computer based information systems'

(vi) 2c.2 (audit). Add profession-specific standards:

'- be able to initiate and manage research and development activity'.
- 'be able to design, introduce and evaluate new and improved methods in diagnostics and therapeutic practice'
- 'be able to specify, evaluate and commission new methods of diagnostic and therapeutic practice'

(vii) 3a.3 (safe practice environment). It was suggested that 3a.3 (profession-specific standard) should read:

*'understand sources of hazard in the workplace, including specimens, raw material, clinical and **special waste** and equipment'*

A further profession-specific standard was also suggested:

'be able to advise on legislative compliance and undertake adverse incident investigations'

The group may wish to consider whether being able to advise others on legislative compliance is a threshold competence standard rather than role undertaken at more advanced levels of seniority. The group may also wish to consider whether this is adequately covered by the existing standard 3a.3 which covers the need to be aware of and comply with relevant law and health and safety policies, including incident reporting.

The ACS did not make any suggestions which accorded with those made by the Council's registration assessors.

Dietitians

British Dietetic Association

The response from the BDA was put together following discussion at committee level. All members of the BDA were also given the opportunity to comment.

The BDA made a number of suggestions for changes to the standards. They said (of the profession-specific standards): 'The standards have been adjusted to take account of the changing scope of dietetics, in particular increasing emphasis on the public health field, this […] places more emphasis on working with groups and communities rather than only individuals, and includes prevention along with disease management.'

(i) 1a.1. In order to recognise the preventative role of health professionals it is suggested that the generic standard is reworded to read:

'understand the need to respect, and so far as possible uphold, the rights, dignity and autonomy of every patient including their role in the ***preventive****, diagnostic and therapeutic process'*

For clarity the following change to the profession-specific standard for dietitians is suggested:

'understand the ethical and legal implications of withholding or withdrawing treatment, ***including food and fluids'***

(ii) 1a.6. For clarity, the following rewording is suggested:

'recognise the need for effective self-management of workload ***and use of resources,*** *and be able to practise accordingly'.*

(iii) 1b.4 (communication). The addition of the following is suggested:

'understand the need to use an appropriate interpreter to assist patients whose first language is not English'

This standard is included in the generic standards for the other 12 professions but has been omitted from the dietitian standards. The detailed generic standard under 1b.4 reads:

understand the need to use an appropriate interpreter to assist patients whose first language is not English

(iv) 2a.4 (assessment). The following wording is suggested of the profession-specific standard:

*'- be able to use nutritional analysis programmes to analyse food intake records and recipes and **interpret the results**'*

(v) 2b.1 (research/ problem solving). The following wording is suggested at the end of the profession-specific standard:

*'- be able to use statistical, epidemiological and research skills to gather and interpret evidence in order to make reasoned conclusions and judgments with respect to dietetic practice in **disease prevention and management***'

(vi) 2b.2 (drawing on professional skills). The following additions to the profession-specific standards are suggested:

*'- be able to advise on safe procedures for food preparation and handling, food processing and menu planning, **and the resulting impact on nutritional quality***'

*'- be able to interpret **nutrition information including** food labels which may have nutritional or clinical implication's*

(vii) 2b.3 (management plans). The following additions to the profession-specific standards are suggested:

*'- understand the significance and potential impact of non-dietary factors when helping individuals, groups **and communities** to make informed choices about their dietary treatment and health care'*

*'- be able to assist individuals, groups and **communities** to undertake and to become committed to self-care activities including diet, **physical activity** and other lifestyle adjustments'*

(vii) 2b.5 (record keeping, generic). The following re-wording is suggested:

*'be able to keep accurate, legible records and recognise the need to handle these records and **all other** information in accordance with applicable legislation, protocols and guidelines'.*

[this rewording removes the word 'clinical' from the standard]

(viii) 2c.2 (audit, reflect, review). The following additions to the generic and profession-specific standards are suggested:

'understand the principles of ***governance frameworks***' [in place of quality control and quality assurance, generic standard]

- be able to maintain an effective audit trail and work towards continual improvement ***in practice***' [generic standard]

'- be able to adapt dietetic practice as a result of unexpected outcomes or further information gained during the dietetic intervention' [profession-specific]

(ix) 3a.1 (knowledge, understanding, skills). The following change is suggested:

*'- understand sociology, social policy, psychology, public health and educational methods relevant to the dietetic management of individual clients****, groups or communities***'

(x) 3a.2 (translating knowledge into practice). The following changes are suggested:

'- know how professional principles are expressed and translated into action through a number of different assessment, treatment and management approaches and how to select or modify approaches to meet the needs of individuals**, groups or communities**' [generic]

'- use clinical reasoning to give practical, realistic, impartial and relevant nutrition and dietetic advice and information to an individual' [profession specific]

Occupational therapists

College of Occupational therapists

The response of COT was complied following consultation with Committee, Board and Council members representing practice, education and research.

They expressed the view that the existing standards placed focused too much on the biomedical model rather than the bio-psychosocial model which is the basis for occupational therapy practice.

The following comments and suggestions were made:

(i) 1a.1 it was suggested that the following should be added:

'understand what is required of them by the profession of occupational therapy'

It is submitted that this suggested standard is ambiguous and it is unclear how this standard could be applied.

The group may consider that the Council's standards in their entirety (together with best practice guidance produced by other organisations) constitute what is required of a registrant as a member of their profession.

(ii) 1a.5 (knowing the limitations of practice). In order to encompass the role of occupational therapy in health promotion, it was suggested that a profession-specific standard be added:

'be able to recognise the potential of occupational therapy in new and emerging areas of practice'

(iii) 1a.8 (career-long learning). It was suggested that the standard be reworded to read:

'understand the need for personal development planning to support career-long self-directed learning'

(iv) 1b.1 (professional scope of practice). It was suggested that this should read:

*'….be able to make **appropriate and timely** referrals'.*

(v) 1b.2 (working with other professionals). It was suggested that a profession-specific standard be added to read:

'understand the need to work across statutory and non statutory sectors'

This suggestion accords with comments made by the Council's registration assessors for occupational therapy.

(vi) 2a.2 (assessment techniques). It was suggested that the following should be added:

'[be able to] select and use relevant assessment tools'

(vii) 2a.2. It was suggested that the following rewording should take place. The existing profession-specific standard reads:

'be able to use standardised and non-standardised assessments to gather information in relation to dysfunction and environmental barriers'

The following rewording was suggested:

'be able to use standardised and non-standardised assessments ***appropriately*** *to gather information in relation to* ***the client's functional level and taking account of the environmental context****'*

(viii) 2b.1 (research and reasoning). It was suggested that the second sub-standard should be reworded to read:

'…participate in audit procedures ***ethically****'*

(ix) 2b.2 (profession specific), It was suggested that the profession-specific standard should be reworded to read:

'be able to use ***and understand*** *the established theories, models, frameworks, and concepts of occupational therapy'*

(x) 2b.3 (formulating management plans). The following rewording was suggested of the last profession-specific standard:

'be able to select, develop or modify therapeutic media that enable clients to build on their abilities and to ***enhance function***'

The remainder of the standard should form part of a separate standard to read:

'- be aware of the full range of occupations used in intervention, including creative and practical activities and environmental adaptations, and that the occupations used should reflect individuals' particular needs, ***in relation to*** *self-care, productivity and leisure'*

(xi) 2b.5 (record keeping). It was suggested that 'clinical' in the first sub-standard should be replaced with 'relevant' and with 'client' in the second sub-statement.

(xii) 2c.1 (monitor/review planned activity). It was suggested that we add 'inform' to the fourth sub-standard.

(xiii) 2c.2 (reflect/review). It was suggested that the first sub-statement should read:

'understand the principles of quality control and quality assurance ***in recognising the need for the implementation and management of change****'*

(xiv) 3a.1 (knowledge, understanding, skills). It was suggested that the 5th and 7th blue statements should be removed.

(xv) 3a.1. It was suggested that the 11th sub-standard should read:

'be aware of social, housing, environmental ***and work related*** *policies and services and their impact on human need within a diverse society'*

(xvi) 3a.3 (health and safety). The following changes were suggested:

Third sub-statement – we should refer to '*personal protection techniques'* rather than equipment.

Profession-specific standard should read '*manual handling'* rather than 'moving and handling'.

Operating Department Practitioners

Association of Operating Department Practitioners

The response from the AODP was put together following the feedback of members through their professional journal.

The AODP did not consider any of the generic or detailed generic standards to be irrelevant.

They suggested that 1a.8 could be expanded by making clearer that this refers to keeping CPD and keeping skills and knowledge updated.

As applicants are currently being accepted for ODPs via grandparenting arrangements, the standards of proficiency for Operating Department Practitioners are not within the remit of this review. Therefore, no comments were received regarding the profession-specific standards. The profession-specific standards will be subject to a 'mini-review' following the end of the grandparenting period.

Orthoptists

British and Irish Orthoptic Society

The response from the BIOS was provided by two members of the Professional Development Committee.

There were no other specific comments in addition to those detailed about autonomy and accountability. The BIOS concluded that the generic and profession-specific standards were generally appropriate for orthoptics.

Paramedics

British Paramedic Association

The BPA commented on the introduction to the standards. They suggested that we might 'direct registrants to their professional body and to curriculum guidance that clearly articulates what the scope of practice'. They were supportive of the standards being kept under review.

The following suggestions were made:

(i) 1a.3 (confidentiality and consent). It was suggested that to reflect that consent for treatment is not always possible, especially in emergency situations, we made the following amendment:

*'be able to maintain confidentiality and **try to obtain** informed consent'*

The existing standard relates to a registrant the point of entry having the skills/ understanding to be able to maintain confidentiality and obtain consent.

The principles of confidentiality and consent relating to continuing registration are covered by the standards of conduct, performance and ethics in paragraphs 2 and 9.

The group may therefore wish to consider whether this extra wording is necessary.

(ii) 1a.8. It was suggested that as health professionals often perform multiple roles we should remove reference to '*career-long'* learning in favour of '*life-long learning'*.

(iv) 1b.4 (communication skills). The following standard was suggested:

'be able to identify anxiety and stress in patients, careers and others, and recognise the potential impact upon communication'

(v) 1b.5 (communication skills). The following standard was suggested:

'*be able to use effective communication skills in the reception and identification of patients, and transfer of patients to the care of others'*

(vi) 2a.2 (assessment techniques). The following standards were suggested:

'be able to use observation to gather information about the functional abilities of patients understanding the need to consider the assessment of both health and social

care needs of patients and carers and to ensure that the appropriate care pathways are accessing to benefit the patient'.

And

'be able to understand the values, beliefs and interests of patients and their families and carers'.

The group may wish to consider whether the second of these suggestions is more appropriately located in standard 1b: professional relationships. The group may further wish to consider whether this is encapsulated in the following standards:

1b.4. In particular:

- understand how communication skills affect the assessment of patients, clients and users, and how the means of communication should be modified to address and take account of factors such as age, physical and learning disability

- be aware of the characteristics and consequences of non-verbal communication and how this can be affected by culture, age, ethnicity, gender, religious beliefs and socio-economic status

(vii) 2b.3 (management plans). The following was suggested:

'understand the need to demonstrate sensitivity to the factors which shape lifestyle which may impact on the individual's health and affect the interaction between client and paramedic'

(viii) 2b.4 (diagnostic/ monitoring procedures). The following profession-specific standards were suggested:

'be able to modify and adapt practice to emergency situations'.

'promote and comply with measures designed to control infection'.

The group may wish to consider whether the second of these suggestions is adequately covered by generic standard 3a.3. In particular:

- be able to establish safe environments for clinical practice, which minimise risks to patients, clients and users, those treating them, and others, including the use of hazard control and particularly infection control.

(ix) 2b.5 (record keeping). It was suggested that this standard might be reworded to read:

'be able to maintain records appropriately and share findings with other health care personnel in the patient care pathway as appropriate to the needs of the patient'

(x) 3.a1 (knowledge, understand, skills). The following changes were suggested:

Biological science section:

[Replaces " human growth and development across the lifespan"]

'- be aware of the main sequential stages of normal development, including cognitive, emotional and social measures of maturation through the human life-span

- understand normal and altered anatomy and physiology throughout the human life-span

- understand relevant physiological parameters and how to interpret changes from the norm

- recognise disease and trauma processes, and how to apply this knowledge to the planning of the patient's pre-hospital care'

3a.1 Behavioural science section

'- understand that aspects of psychology and sociology are fundamental to the Paramedic's role in developing and maintaining effective working relationships'

3a.1 Clinical science section

'understand the principles underpinning the safe and effective utilisation of equipment that is used for diagnostic, monitoring or therapeutic purposes in health care generally and in particular those devices which is used in unscheduled and emergency care of the paramedic in the clinical setting'

(xi) 3a.2. The following is suggested:

'understand how to store, issue, prepare audit and administer prescribed drugs to patients, and monitor the effects of drugs on patients'

The group may wish to consider the degree to which this suggested standard is adequately encapsulated within the existing standards:

2c.1

be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly [generic]

3a.2

- know how and when to administer drugs as appropriate, including knowing the relevant indications, contraindications, therapeutic effects, side effects and dosages, and the relevant basic pharmacology, including the pharmacodynamics and pharmacokinetics [profession-specific]

(xii) 3a.3. The following standard was suggested:

'- understand the nature and purpose of sterile fields, and the practitioner's individual role and responsibility for maintaining them'

Physiotherapists

Chartered Society of Physiotherapy

The response from the CSP was put together following discussion at council, committee and board level. It also included input from members of the HPC convened physiotherapy working group who looked at the standards first time round.

A number of comments were made about the standards and these are summarised as follows:

(i) The 'formulaic' and 'mechanistic' style of the standards, whilst making them easy to read for a broad range of audiences, fails to 'capture important nuances to do with safe, effective and contemporary professional practice'.

(ii) The format of the standards is couched in terms of 'outcomes' rather than a conventional standards format. The CSP encouraged the translation of the existing standards of proficiency to a more conventional standards format. They said that this was important given the standards' status and would 'maximise the documents' clarity'.

(iii) There is variation amongst the profession-specific standards. The CSP said: 'While each of the profession-specific standards should have a character that reflects the nature of practice within that profession, it would seem reasonable that the documents adhere to a similar format since they have the same applications'.

(iv) The format of generic, detailed generic and profession-specific standards can 'quite easily [be] misunderstood and misconstrued by readers'. Attention should be given to more clearly explaining the difference between the two presentations of the standard and providing clearer links to the different sections of the document

(vi) There is a need to clearly state the role of the standards and how they relate to HPC activity and the relationship of the standards to other frameworks.

(vii) Terms such as 'proficiency' and 'fitness to practise' should be clearly defined.

The group may wish to consider whether the changes proposed to the introduction of the standards go some way to address some of these concerns and whether any changes might be necessary.

If thought to be helpful, a glossary could be added to the standards to clearly explain terms such as proficiency and fitness to practise.

The standards and language

The CSP commented on the language used in the standards. In particular, the use of verbs such as 'understand' and 'recognise' is questioned. The CSP questioned 'how simply understanding the need for an activity or recognising the need for something can be sufficient to protect the public'.

The legal basis for the language of the existing standards is acknowledged, however concern is raised as to how individuals compliance with the standards can be measured. In particular, whether we can interpret the standards in terms of 'actual behaviour or in terms of potential capacity to do something'.

The group may wish to consider two papers in relation to these concerns:

(i) The legal context (appended at appendix 3)
(ii) The standards and language (PLG papers 7th March 2006)

The language of the existing standards is related to their legal context as threshold competence standards for admission to the register.

Suggested changes:

Generic standards:

(i) 1a.2 should state that registrants should practise in an "*anti-oppressive manner*", as well as a "*non-discriminatory*" one.

(ii) 1a.5 should stress the importance of individuals not practising outside the "limits of their practice".

(iii) 1b.1 could usefully be expanded to indicate that registrants should not work beyond their scope of practice without developing their knowledge and skills appropriately.

The group may wish to consider whether the revisions of standard 1a.5 suggested on pages **6 to 8** of the paper adequately address the idea of an understanding of scope of practice at the point of entry to the register.

The importance of acting within the limits of your skills, knowledge and experience as a standard of continuing registration is stated in paragraph 6 of the standards of conduct, performance and ethics.

The group may wish to consider whether concepts around scope of practice are adequately addressed by the proposed revisions to the introduction.

(iv) 1b.4 and 1b.5 should stress that communication must revolve around working in partnership with individuals, with due sensitivity to their interest, needs and concerns.

Detailed generic standards

(i)1a.8 should include a sub-clause to highlight individuals' need to develop their practice in response to changing need and demand.

(ii) 1b.2 should include a sub-clause to indicate that registrants need to understand, and respond appropriately in their professional practice, to changes in health and social care policies and how health and social care is organised.

(iii) It is unclear under standard 2b.2 how the sub-clause concerning IT relates to registrants' ability "to make professional judgements".

Appendix 3

Profession-specific standards

General comments

(i) Lack of emphasis on healthcare professionals working in partnership with patients, clients and users
(ii) The standards 'do not reflect the complex melding of knowledge, understanding, skills, behavioural attributes and professional judgement that makes up safe, effective and legal physiotherapy practice'
(iii) Absence of psycho-social dimensions of practice

The following points, it is suggested, need more emphasis:

(i) Understanding, and acting on, the duties, obligations and privileges that professional self-regulation carries, including those, crucially, to do with professional autonomy

(ii) Taking a holistic approach to the management of individuals' problems and conditions, informed by a commitment to working in partnership with patients

(iii) Assessing patients safely and effectively taking account of physical, psychological, social and cultural needs

(iv) Applying clinical reasoning, taking account of information and scientific evidence in selecting, justifying and reviewing appropriate treatments

(v) Formulating a treatment plan that is justifiable in terms of physiotherapy management and implemented in partnership with the patient

(vi) Understanding the scientific basis of physiotherapy and applying knowledge of this to their practice

(vii) Participating in the education of students, physiotherapists, health and social care workers, patients and carers

(vii) Having the broader capacity to teach and present information to individuals and groups.

New standards

The following profession-specific standards were suggested:

(i) 2a.1 (gather appropriate information) - *'gather and record information from a wide range of sources and by a variety of methods'*

(ii) 2a.2 (assessment techniques) -'*recognise the physical, psychological, social and cultural needs of individuals and communities'*

(iii) 2a.4 (analyse and evaluate information) – *'analyse and synthesise information gathered from assessment data and the clinical problem-solving processes'*

(iv) 2b.2 (drawn on appropriate knowledge and skills) – *'apply clinical reasoning, taking account of available information and scientific evidence, in selecting, justifying and refining appropriate treatments, together with the ability to:*

- reflect on past and present clinical decisions and outcomes from practice'
- bring together knowledge from the literature and clinical experience to inform the interpretation of patient data
- think critically about personal knowledge and expertise in order to make sound and defensible clinical decisions
- engage in decision analysis where mutually exclusive alternative options are considered in light of patient context and preference

The group may wish to consider the extent to which these points are encapsulated in the existing standards 2b.1, 2b.2 and 2c.2.

(v) 2b.3 (management plans) – *'make the patient central to the delivery of care, making decisions, setting goals and constructing specific plans to achieve goals taking account of relevant contextual factors; apply problem-solving and clinical-reasoning to assessment findings to plan, prioritise and implement appropriate physiotherapy'*

The group may wish to consider the extent to which ideas around setting plans, problem solving and clinical reasoning are adequately addressed by the existing standards at 2b.1 and 2b.3.

(vi) 2c.1 (monitor and review) – *'use clinical reasoning approaches to select, justify and review appropriate treatments; develop and use outcome measures for evaluating physiotherapy; make judicious use of the best available information and evidence'*.

The group may wish to consider the extent to which ideas around setting plans, problem solving and clinical reasoning are adequately addressed by the existing standards at 2b and 2c.1.

(vii) 2c.2 (audit, reflect, review) – *'evaluate the treatment plan to ensure that it is effective and relevant to a patient's changing circumstances and health status'*

The group may wish to consider the extent to which ideas around treatment plans and the modification of such plans in response to changing circumstances are adequately addressed by the existing standards at 2b.3.

(viii) 3a.1 (knowledge, understanding, skills) – *'demonstrate a knowledge and understanding of the behavioural sciences and how these underpin physiotherapy practice, including:*

- the psychological, social and cultural factors that influence individuals in health and illness, including their responses to the management of their health status and related treatment
- how psychology, sociology and cultural diversity inform an understanding of health, illness and health care in the context of physiotherapy and the incorporation of this into professional practice
- theories of communication and their relevance to effective interaction with patients, carers, colleagues, managers, and other health and social care professionals
- team working and leadership'

Prosthetists and Orthotists

British Association of Prosthetists and Orthotists

The response from BAPO was put together following the comments of members of the executive committee.

The follow comments and suggestions were made:

(i) BAPO did not feel that any standards needed to be removed or added.

(ii) 2b.4 (profession-specific). It was suggested that the fourth standard should read:

be able to provide, where appropriate, a suitable case **or electronic data** to accompany the written information

(iii) It was suggested that in generic standard 2b.4, the word 'skilfully' should be substituted for 'appropriately'.

(iv) 2c.1, 5th bullet (detailed generic). BAPO commented: 'I'm just a little concerned with this wording and feel it could justify 'maverick' practice':

Radiographers

Society and College of Radiographers

The SOR put together their response following feedback from members and detailed technical work by officers of the society. The recommendations were then agreed by the society's council at their meeting in February 2006.

The views of the society about the comments made by registration assessors are incorporated into their suggestions.

The SOR said that they considered the generic and detailed generic standards to be appropriate.

The following changes were suggested:

Generic standards:

i) 1a.8. The following rewording is suggested in order to reflect forthcoming CPD requirements:

"understand the need for career-long self-directed learning and provide evidence of continuing professional development"

(ii) 2b.2 (drawing on professional knowledge). In order to reflect the importance of clinical guidelines, the following additional standard is suggested:

"be able to understand and apply national clinical guidelines (ie NICE, SIGN) where appropriate within the care and management of patients and clients"

(iii) An additional standard is suggested about the duty of health professionals to be alerting to the risks of abuse:

'understand the concept and risks surrounding child and elder abuse and neglect and if the registrant has cause to believe that abuse / neglect is suspected with patients / clients in their care that reporting procedures are immediately implemented'

The group may wish to consider whether this is appropriate as a threshold entry standard rather than an aspiration or a detailed explanation of best practice.

It is submitted that the underlying philosophy of this standard is encompassed in standard 1a.1 which reads:

– understand the need to respect, and so far as possible uphold, the rights, dignity and autonomy of every patient, client and user including their role in the diagnostic and therapeutic process

Furthermore, as a standard for continuing registration, paragraph 1 of the standards of conduct, performance, and ethics says:

'You must act in the best interests of patients, clients and users… You must not do, or allow anything to be done, that you have good reason to believe will put the health or safety or patient, client or user in danger. This includes both your own actions and those of others.'

(iv) In order to acknowledge the role of IT the following is suggested:

'understand the principles of and utilise electronic health records and relevant IT systems within own practice'

The group may wish to consider whether the idea of IT skills relevant to practice is encapsulated in the existing standard 2b.2 which reads:

- be able to demonstrate a level of skills in the use of information technology appropriate to their profession

Profession Specific

i) 1a.1. In order to reflect the legislation that surrounds the full scope of radiography practice the following rewording to the profession specific standards are suggested:

'- be able to practice in accordance with current legislation governing the use of ionising and ***non-ionising*** *radiation for medical and other purposes'*

(ii) For clarity the following rewording of 1b.2 (profession-specific) concerning awareness of health services is suggested:

'- *be aware of the general working of health* ***and social*** *care services'*

It is further suggested that this might be a generic standard for all health professionals.

(iii) 1b.4 (communication skills). It is suggested that a profession-specific standard be added for therapeutic radiographers only to recognise that radiographers are involved in giving advice and information to patients and families:

'*understand the information and psychosocial needs of patients and their families / carers'*

(iv) 1b.4. It is suggested that we reword the profession-specific standard which addresses the need for diagnostic radiographers to understand the psychology of illness to reflect the accuracy and currency of the term 'diagnostic imaging examinations'. The reworded standard would read:

'understand the psychology of illness, anxiety and uncertainty and the likely behaviour of patients undergoing ***diagnostic imaging examinations****, as well as that of their families and carers'*

(v) The following rewording of standard 2b.1 (profession-specific) is suggested:

'understand the problems encountered at ***the patient or client /radiation / technology interface*** *and be able to find appropriate solutions to such problems'*

The rewording is suggested to 'clarify the complex triangular nature of the three separate factors that the radiographer must consider when problem-solving within his/her practice'. The term client is suggested as with some services (such as breast screening), the service user is not a patient.

vi) To reflect standard practice and the content of undergraduate curricula, the following rewording of profession-specific (diagnostic radiographers only) standard 2b.4 is suggested:

'be able to perform a ***standard head computed*** *tomographic (CT) examination, assist with CT examinations of* ***the spine****, chest and abdomen in acute trauma and to contribute effectively to other CT studies'*

iii) 2b.4. The following profession-specific standard for therapeutic radiographers in suggested:

'be able to interpret /evaluate images obtained during radiotherapy planning and treatment'

(iv) 2c.2. It is suggested that a profession-specific standard be added:

'be able to analyse and review the results of audit to inform a change in practice when required'

(v) 3a.1. An additional profession-specific standard is suggested for therapeutic radiographers to reflect the need for 'a safe and effective treatment course for patients receiving radiotherapy':

'be able to recognise changing signs and symptoms, progression of disease, decide not to treat (if necessary) and make appropriate referrals before administering any further radiation treatment'

(vi) 3a.1. An additional profession-specific standard for therapeutic radiographers is suggested:

'know the physical and scientific principles on which image formation using ionising and non-ionising radiation is based'

This standard is suggested to recognise that therapeutic radiographers 'undertake imaging examinations in the planned phases and during radiotherapy treatments'.

(vii) 3a.1. A rewording of the profession-specific standard for diagnostic radiographers is suggested in order to reflect practice and the undergraduate curriculum. This reads:

'know the physical and scientific principles on which image formation using ionising *and non-ionising* radiation is based'

(viii) 3a.1. An additional profession-specific standard for diagnostic radiographers is suggested:

'*be able to distinguish disease and trauma processes as they manifest on diagnostic images, and to appraise the diagnostic image information for clinical manifestations and technical accuracy, and take further action as required'*

This addition is suggested because it is 'now a normal expectation that radiographers provide initial clinical interpretations of standard diagnostic imaging examinations through, for example 'red dot' and written comment systems, as well as verbally through inter-professional working'.

(ix) 3a.3. It is suggested that the following standards become generic for all professions:

'be aware of immunisation requirements and the role of occupational health'

'know the correct principles and applications of disinfectants, methods for sterilisation and decontamination and dealing with waste and spillages correctly'

Speech and language therapists

The Royal College of Speech and Language Therapists

The response from the RCSLT was put together following discussion by the Professional Development and Standards Board.

The Board agreed that no changes were needed to the standards at this time. Suggestions were also made for how the introduction could be improved (see page 6).

Conclusion

The PLG is invited to discuss the feedback received from the professional bodies.

The PLG may particularly wish to consider changes to the generic standards in light of all the evidence received, in particular, in the areas of autonomy and fitness to practise (pages 7 to 10).

Any decisions made by the PLG can be brought back to the next meeting and reviewed in light of further evidence considered by the group.

The PLG is reminded that:

(i) any standards should be necessary competence standards for the safe and effective practice of a profession;

(ii) any amendments or additions to the existing standards should be necessary in order to reflect changes in practice or terminology or to improve the clarity or accuracy of the standards;

(iii) any standards should conform to the Council's obligations under the Disability Discrimination Act.

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