EXPLANATORY MEMORANDUM TO

THE COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE (APPOINTMENT, PROCEDURE ETC.) REGULATIONS 2008

2008 No. 2927

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This instrument replaces the Council for the Regulation of Health Care Professionals (Appointment etc.) Regulations 2002. It will enable reform of the Council to reduce it from 19 to 9 members and it will no longer have any regulatory body nominees. This mirrors the provisions of the more board-like strategic councils for the healthcare regulatory bodies themselves, reflects the Council's changing role and will make it independent of the regulatory bodies and the professionals they regulate.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

4. Legislative context

4.1 The Council for the Regulation of Health Care Professionals was established under Section 25 of the National Health Service Reform and Health Care Professions Act 2002 ('the Health Care Professions Act 2002'). Sections 113 to 118 of the Health and Social Care Act 2008 amend its name to the Council for Healthcare Regulatory Excellence (CHRE) and make amendments to its constitution and functions and the way members are appointed.

4.2 These Regulations make provision with regard to the conditions of appointment and tenure of the chair and non-executive members of the Council. They are made by exercising the powers conferred by paragraph 6 of Schedule 7 to, and section 38(5) and (7) of the Health Care Professions Act 2002.

4.3 These Regulations are subject to the negative resolution procedure.

5. Territorial extent and application

5.1 This instrument applies to the whole of the United Kingdom.

6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

What is being done and why

7.1 The White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (published in 2007) set out the Government's intention to reform the Council to strengthen its role as an independent voice for patients and the public on healthcare professional regulation issues. The current Council is made up of 19 members:

- 9 members,1 nominated by each of the healthcare regulatory bodies, which in practice has been the presidents of these bodies
- 10 public members who do not belong to any of the regulated healthcare professions. Of these, seven are selected by the Appointments Commission, and Scotland, Wales and Northern Ireland each nominate a member.

7.2 Following the proposals in the White Paper and changes in the Health and Social Care Act 2008, regulations are setting up a new model for the Council. These changes will mirror the provisions for more board-like strategic councils for the healthcare professional regulatory bodies themselves, and reflect the Council's changing role.

7.3 The reformed Council will be smaller, consisting of nine members, two executive, six non executive members and a chair. It will be independent of the regulatory bodies and the professionals they regulate as there will no longer be any of the regulatory body nominees. The non-executive members will reflect patient, public, education and employer issues as well as bringing individual skills required to fulfil the Council's strategic function, as an authoritative independent voice on the regulation of professionals.

7.4 The Council's statutory functions as set out in the Health Care Professions Act 2002 are set out below:

- promote the interests of the public and patients in relation to the performance of statutory functions by regulatory bodies
- promote best practice in regulating healthcare professions
- develop principles for good, professionally-led regulation of healthcare professions
- promote co-operation between regulators and other organisations performing similar functions.

7.5 The Health and Social Care Act 2008 provides for the Council to have a new main objective. The new objective requires the council in exercising its functions under the 2002 Act to promote the health, safety and well being of patients and other members of the public.

7.6 The changes will ensure that the Council acts as an independent voice for patients and the public on healthcare professional regulation issues, consulting the public and organisations representing the interests of patients, and having more power to champion the health, safety and well-being of patients in their dealings with the health regulators.

7.7 The regulations will provide the necessary criteria for membership of the reformed Council for the Chair and non-executive positions. They have been developed following discussions with the Council. They do not apply to the two executive posts on the Council, as these posts will be filled by its employees and subject to its own terms and conditions of employment.

7.8 Regulation 2 makes provision in relation to the disqualification of certain categories of people from being the chair or non-executive members of the Council. They are disqualified if they do not live or work wholly or mainly in the United Kingdom and if any of the paragraphs (2)(a) to (2)(j) apply. For example, they will be disqualified if they have been convicted of certain types of offences. Chairs or members of regulatory bodies are disqualified along with members of regulated professions, to ensure the Council's independence from them.

7.9 Regulation 3 makes provisions for the appointment of the chair and non-executive members to the Council for a term of four years. This is in line with the recommendations made in the paper 'Implementing the White Paper Trust, Assurance and Safety: Enhancing confidence in healthcare professional regulators' published June 2008. The regulation also provides that no Council member should serve any more than eight years in any period. This means that any member of the Council who has served eight years or more will have to stand down and not be eligible to be a council member again. Regulation 3 also makes provisions in the case that a Chair or non-executive member resigns (ie is not suspended or removed).

7.10 Regulation 4 makes provision in the event that the Chair is likely to be absent for any period. If the Chair is absent from a meeting, the Council may nominate another non-executive member to serve as Chair for that meeting. If however, it is likely that the Chair will be absent for more than one meeting, or at least a month, or the office of chair is vacant for a longer period, the Council may nominate a member to act as "deputy" during the absence of the Chair or the vacancy.

7.11 Regulation 5 prescribes the circumstances in which the Council may suspend members. This includes suspension because they no longer live or work wholly or mainly in the United Kingdom, because any of the provisions of Regulation 2(2)(a) to (2)(j) now apply, because they are the subject of any criminal investigation or proceedings, or because they are subject to investigation or proceedings concerning their professional conduct.

7.12 Regulation 6 prescribes the circumstances in which the Chair and non executive members may be removed from office. Removal is by the Privy Council in the case of the Chair and in the case of a non-executive member, by whoever appointed that member under Paragraph 4 of Schedule 7 of the Health Care Professions Act 2002 as amended by Section 114 of the Health and Social Care Act 2008. The removal process will ensure that the body that makes the appointments is also responsible for removal and provides a clear process that is independent of the Council itself.

7.13 Regulation 7 allows the Council to make provisions for committees, to enable delivery of its work programme and objectives. This may mean calling upon non-members of the council to undertake this work. In doing so, these non-members will be subject to certain criteria laid out under Regulation 2 (with the exception of regulation 2(2)(i) and (j) – ie committee members may be chairs or members of regulatory bodies, or members of regulated professions).

7.14 Regulation 8 enables the first appointment of tenure for three of the non-executive council members to be for a period less than four years, but not to be less than two years. This will allow for appointments for different durations. Going forward this will mean that only a proportion of the Council will need to be replaced at the end of each tenure, thus allowing for continuity and stability of business.

7.15 Regulation 9 revokes the Council for the Regulation of Health Care Professionals (Appointment etc.) Regulations 2002, which these regulations replace.

Consolidation

7.16 This instrument does not amend any other instrument. Therefore, no consolidation is necessary.

8. Consultation outcome

8.1 The Department of Health published a consultation paper 'The Council for Healthcare Regulatory Excellence (CHRE) Draft Regulations 2008 – A paper for consultation' accompanied by draft regulations, setting out proposed conditions for the appointment and tenure of the chair and non-executive members of the Council. The consultation took place over an eight-week period between 22 July and 16 September 2008.

8.2 The Cabinet Office Code of Practice on consultations suggests best practice is for consultations to run for a minimum of 12 weeks, at least once during the formulation process of each policy. However, Ministers decided in this case to shorten the consultation period to 8 weeks. This was essentially for three reasons:

- extensive consultation on the principles underpinning the new Council had already taken place, including debates in Parliament about the Health and Social Care Act 2008;
- the Council (the key stakeholder) has been closely involved in the process of producing the Regulations; and
- there is an expectation that the new Council will be operational from 1 January 2009. Some members of the current Council are leaving and there is concern it may become inquorate. Therefore, the intention is to be in a position to put in place the new legislative arrangements as soon as practicable after the 2008 Regulations are made.

The Department contacted interested regulatory bodies, professional bodies, patient groups and professionals, alerting them to the consultation. Respondents were asked to fill in a questionnaire response form and return it either electronically or by post to the Department.

8.3 In total, 22 responses were received. Nine responses were made in the form of a general letter or e-mail reply, rather than using the questionnaire. Of these, four were general expressions of support and one concentrated entirely on Regulation two. All responses were reviewed as part of the consultation process. They represented a diverse mix of bodies/organisations and individual professionals. This included primary stakeholders in the field of regulation of health professionals.

8.4 The majority of respondents were in favour of the proposals with no more than 12% objecting to any individual Regulation. Some comments have been accepted, resulting in the Regulations as described in paragraphs 7.9 to 7.16 above. A full report of the consultation and the amendments to the Regulations that have resulted is available on the Department of Health website: www.dh.gov.uk.

9. Guidance

9.1 The Department will not be issuing any guidance.

10. Impact

10.1 There is no impact on business, charities or voluntary bodies.

10.2 There is no impact on the public sector.

10.3 An Impact Assessment is attached to this memorandum.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring and review

12.1 The Council will be reduced from 19 to 9 members and it will no longer have any regulatory body nominees. There will be new regulations for appointment, suspension and removal of the Chair and non-executive members and for deputising arrangements in the event the Chair is absent. The Chair and non-executive members will be appointed for a period of four years, appointments will be staggered and they will only be able to serve on the Council for a maximum of eight years. The Council will have provisions to form committees.

12.2 These arrangements will be subject to internal review in 2011 and the legislation may be amended accordingly.

13. Contact

Peter Reitler at the Department of Health Tel: 0113 254 5729 or e-mail: peter.reitler@dh.gsi.gov.uk can answer any queries regarding the instrument.

Summary: Intervention & Options

Department /Agency:	Title:	
DH	Impact Assessment of the Reformed CHRE Council	
Stage: Implementation	**Version:** 2	**Date: 30 October 2008**
Related Publications: White Paper - "Trust, Assurance and Safety" and the Health and Social Care Act 2008		

Available to view or download at:
http://www.dh.gov.uk

Contact for enquiries: Peter Reitler **Telephone:** 0113 254 5729

What is the problem under consideration? Why is government intervention necessary?

The White Paper 'Trust, Assurance and Safety ' set out the Government's intention to reform CHRE to strengthen its needed role as an independent voice for patients and the public on healthcare professional regulation issues. The Health and Social Care Act 2008, provides for a new model for the Council mirroring provisions for more board-like strategic councils for the healthcare professional regulatory bodies themselves and reflecting the Councils changing role.To do this, it needs to become independent of the regulatory bodies and the professionals they regulate.

What are the policy objectives and the intended effects?

The regulations will provide the necessary criteria for membership of the reformed Council. For example, they state who can/cannot be a member, terms of appointment and removal and suspension from office. The changes in the Health and Social Care Act 2008 now being implemented through these regulations will ensure the Council acts as an independent voice for patients and the public on healthcare professional regulation issues, and have more power to champion the health, safety and well-being of patients in their dealings with the health regulators.

What policy options have been considered? Please justify any preferred option.

Policy options were considered prior to Parliamentary consideration and approval of the Health and Social Care Act 2008, which requires these Regulations to be made.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? June 2011

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

Ben Bradshaw .....Date: ***10th November 2008***

Summary: Analysis & Evidence

Policy Option:	Description: CHRE Appointment Regulations

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ 17,400	1
Average Annual Cost (excluding one-off)	
£ 99,800	

Description and scale of **key monetised costs** by 'main affected groups' The attached regulation provides for a fully appointed council, with fewer members than present. Costs of the appointments will be offset by savings.

Total Cost (PV) **£ 383,300**

Other **key non-monetised costs** by 'main affected groups'

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0	1
Average Annual Benefit (excluding one-off)	
£ 213,600	

Description and scale of **key monetised benefits** by 'main affected groups' The changes set out in the regulations provide for a smaller Council than the existing therefore we expect savings.

Total Benefit (PV) **£ 784,600**

Other **key non-monetised benefits** by 'main affected groups' Enhanced confidence in regulation through smaller, board-like strategic council; independently appointed and independent of the regulatory bodies and the professionals they regulate; representative of members from all Home Countries.

Key Assumptions/Sensitivities/Risks

Price Base Year 2008	Time Period Years 4	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) **£ 401,300**

What is the geographic coverage of the policy/option?			UK	
On what date will the policy be implemented?			January 2009	
Which organisation(s) will enforce the policy?			CHRE	
What is the total annual cost of enforcement for these organisations?			£ 0	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			No	
What is the value of the proposed offsetting measure per year?			£ 0	
What is the value of changes in greenhouse gas emissions?			£ 0	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ 0 Decrease of £ 0 **Net Impact** **£** 0

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Background

Current Council

The Council for the Regulation of Health Care Professionals was established under the National Health Service Reform and Health Care Professions Act 2002 and has been operational since April 2003. The Health and Social Care Act 2008 amends its name to the Council for Healthcare Regulatory Excellence (CHRE) and makes amendments to its constitution and functions and the way members are appointed. The Council's statutory functions as set out in the 2002 Act are to:

- Promote the interests of the public and patients in relation to the performance of statutory functions by regulatory bodies;
- Promote best practice in regulating healthcare professions;
- Develop principles for good, professionally-led regulation of healthcare professions;
- Promote co-operation between regulators and other organisations performing similar functions.

The Council oversees the work of the nine health regulators. In order to comply with its statutory obligations, it conducts an annual performance review of the functions of the regulatory bodies. The regulators supply the Council with detailed information, in a standardised format, on their organisational structure, functions and decisions made. Each review of the regulator is published on the Councils website.

The current Council is made up of 19 members:

- 9 members, 1 nominated by each of the regulatory bodies
- 10 public members who do not belong to any of the regulated healthcare professions. Of these, seven are selected by the Appointments Commission, and Scotland, Wales and Northern Ireland each nominate a member.

Reformed Council

A new model for a reformed Council membership is being introduced following the proposals in the White paper (*Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* published in 2007) and changes required in the Health and Social Care Act 2008. These Regulations are required to implement the Act.

The Foster Review – 'The regulation of the non-medical healthcare professions' published in July 2006 stated that changes to the membership of the Council would be developed which would preserve its lay majority (and UK-wide makeup) while securing a professional voice through appointments against objective criteria. Its close working relations with the regulators would in future need to be furthered by other kinds of contact rather than by Presidents sitting on its Council.

Following Parliamentary debate around the Social Care Act 2008 it was concluded that neither the chair, nor any members of the Council should be members of the healthcare professions regulatory bodies at all, or the professions they regulate. This is to ensure that it can exercise its functions fairly and effectively, so that patients, the public and health professionals can take for

granted that it will act dispassionately and without undue regard to any one particular interest, pressure, or influence. In future, members will be appointed for their knowledge, experience and judgement. This will ensure that the Council is demonstrably independent of any sectoral interests.

The White Paper recommended:

- council members be appointed independently, to enhance public confidence; and
- councils should become smaller and more board-like in order to focus more effectively on strategy.

The reformed Council will be smaller, consisting of nine members, two executive and six non executive members and a chair. It will be independent of the regulatory bodies and the professionals they regulate as it will no longer have any of the regulatory body nominees on the Council.

The Health and Social Care Act 2008 provides CHRE with a new main objective. The new objective requires the council in exercising its functions under the 2002 Act to promote the health, safety and well being of patients and other members of the public.

The Government expects that the reforms to the regulators and to fitness to practise procedures will provide greater room for the Council to balance its work on scrutiny with enhanced and extended work on best practice and common regulatory issues. Changes to its governance will enable the Council to become independent and more strategic and it will be required by statute to include the views of stakeholders from across the UK in its deliberations.

The changes will ensure that the Council acts as an independent voice for patients and the public on healthcare professional regulation issues, consulting the public and organisations representing the interests of patients, and having more power to champion the health, safety and well-being of patients in their dealings with the health regulators.

In order for the reformed Council to obtain its membership, it is necessary to lay out in regulations the criteria for conditions of appointment, tenure of appointment, cessation, removal and suspension of members from office, transitional arrangements and the appointment of committee members for discrete areas of work it may wish to undertake. This impact assessment and consultation document is aimed at ensuring we have the right regulations in place for the reformed Council membership.

Consultation

The Department of Health published a consultation paper ‘The Council for Healthcare Regulatory Excellence (CHRE) Draft Regulations 2008 – A paper for consultation’ accompanied by draft regulations, setting out proposed conditions for the appointment and tenure of the chair and non-executive members of the Council. The consultation took place over an eight-week period between 22 July and 16 September 2008.

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- extensive consultation on the principles underpinning the new Council had already taken place, including debates in Parliament about the Health and Social Care Act 2008;

- the Council (the key stakeholder) has been closely involved in the process of producing the Regulations; and

- there is an expectation that the new Council will be operational from 1 January 2009. Some members of the current Council are leaving and there is concern it may become inquorate. Therefore, the intention is to be in a position to put in place the new legislative arrangements as soon as practicable after the 2008 Regulations are made.

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The majority of respondents were in favour of the proposals with no more than 12% objecting to any individual Regulation. Some comments have been accepted, resulting in amendment to the Regulations, though not in terms of their effect, impact, or costs. A full report of the consultation and the amendments to the Regulations that have resulted is available on the Department of Health website: www.dh.gov.uk.

Council costs breakdown

The draft regulations provide for the reformed Council to consist of nine members made up of a Chair, six non-executives (of which three are appointed by the Devolved Administrations) and two executive members appointed by the Council. The Appointments Commission will be undertaking the appointments procedure on behalf of the Privy Council for the post of Chair and three non-executive members on behalf of the Secretary of State. These costs are estimated at £23,250.

This is a reduction in council membership from the current 19 of 10 lay members and 9 members from the health regulatory bodies. Therefore, membership of the council costs will reduce. A breakdown has been illustrated below to demonstrate this.

Estimated costs of the current council and the new council are outlined below, with the additional estimated costs of the appointments for the new council

CHRE Council Costs				
New Council	Chair (£s)	Audit Chair (£s)	5 members (£s)	Combined total (£s)
Remuneration	32,060	12,500	37,500	**82,060**
Expenses (estimate)	1,700	1,700	8,500	**11,900**
TOTAL	**33,760**	**14,200**	**46,000**	**93,960**
Current Council	Chair (£s)	Audit Chair (£s)	17 members (£s)	Combined total (£s)
Remuneration	32,060	12,500	127,500	**172,060**
Expenses (estimate)	1,700	1,700	28,900	**32,300**
TOTAL	**33,760**	**14,200**	**156,400**	**204,360**
Appointment Costs	(based on estimate provided by Appointments Commission 22.05.08) (£s)			
Commission Fees	13,000			
Advertisements	10,250			
TOTAL	**23,250**			

NOTES

Expenses are estimated, based on 2007-08 total for Council (18 members: £30,196).
Assumption that remuneration for new Council is the same as the current Council.
Assumption number of meetings same as 2007-08.
Ordinary members receive: £7,500
Appointment costs are based on an estimate prepared by the Appointments Commission for the appointment of Chair & 3 members.
Full complement of current Council is 19 members. One public position has been vacant for 2007-08 following the departure of the previous Chair.

Specific Impact Tests: Checklist

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	No	Yes
Small Firms Impact Test	No	Yes
Legal Aid	No	Yes
Sustainable Development	No	Yes
Carbon Assessment	No	Yes
Other Environment	No	Yes
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	Yes

Annexes

Competition Assessment

No issues have been identified

Small Firms Impact Test

No impact on small firms

Legal Aid

No legal issues identified

Sustainable development

No issues identified

Carbon Assessment

No impact

Other environment

No environmental issues identified

Health Impact Assessment

No issues identified

Race/Disability/gender equality

In drafting the regulations, we have considered the possible impact on equality issues (age, disability, gender, race, religion or belief, and sexual orientation) of the regulations described in this Impact Assessment. The appointments procedure will provide those legal safeguards to ensure that there will be no negative impact on these groups.

Human Rights

No issues identified

Rural Proofing

No issues identified