Exploring a Federal Approach to Voluntary Self Regulation of Complementary Healthcare: Report on the Consultation

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Introduction

This report, prepared by Abigail Masterson and Matthew Barker of Abi Masterson Consulting Ltd., presents the full results of the consultation 'Exploring a Federal Approach to Voluntary Self Regulation of Complementary Healthcare' carried out on behalf of the Prince's Foundation for Integrated Health (The Foundation) during summer 2006. The consultation was a culmination of more than six years work undertaken by the Foundation towards the regulation of Complementary and Alternative Medicine (CAM). The key purpose of the consultation therefore was to gauge the level of support amongst the CAM professions for the development of a federal regulator. A supplementary objective was to stimulate debate about the detail of such a system.

In May 2006, stakeholders (such as professional associations) were sent the Foundation's proposals and a questionnaire. The proposals and questionnaire were also posted on the Foundation's website. The closing date was 28th July 2006. 438 responses were received (of which 123 were submitted electronically).

It was stated in the preamble to the questionnaire that respondents did not have to respond to all the proposals consequently the total number of responses to each proposal does not equal 438. Respondents were asked to give their name, addresses and email details etc in order that any multiple responses could be identified. Respondents were informed that their responses would be used for analysis and might be made public and were asked to indicate if they wished their response to remain private by ticking a box.

General overview of findings

Thirteen questions asked respondents to agree or disagree with a statement, the rest asked for comments related to the detail of the systems, structures and processes likely to be involved. The percentage of responses which supported the 'Do you agree' statements are presented in table 1 overleaf:

Table 1

Question	Agree
Do you agree with the criteria for the professions to be regulated by the federal council?	71%
Do you agree with the proposed fundamental functions and duties of the council?	68%
Do you agree the structure outlined in section 4.5 would be appropriate for membership of the Council?	50%
Do you agree with the proposed council committee structure?	57%
Do you agree with the approach as outlined to the accreditation of courses and qualifications?	56%
Do you agree with the role of the visitor and that the professional associations could provide guidance on their appointment?	58%
Do you agree with the proposal for conjoint validation?	56%
Do you agree there should be a transitional period to enable the setting up of a new council and register?	74%
Do you agree that this [transitional period] should be for a term of not less than two years from the opening of the register?	66%
Do you agree that the new council should consider advanced or specialist-level practice?	53%
Do you agree with the proposed composition and functions of the education and training committee?	57%
Do you agree that provision should be made within the register to accommodate professionals who are using their professional skills in some capacity, but are not involved in patient contact?	66%
Do you agree with the principle of establishing a voluntary federal regulatory body for complementary healthcare professions?	68%

Methodology

The quality of a consultation is generally accepted to be demonstrated in the rigour with which it is conducted and the transparency of the audit trail. Analysis should be systematic and comprehensive. Interpretation should be well supported by the evidence. The design and conduct of the consultation should allow all perspectives to be identified and the audit trail should include a clear description of the methods of analysis used and report all of the findings.

The quantitative data were analysed using SNAP survey software and the percentage and/or absolute numbers of the respondents who responded to each item is presented.

The percentages presented in the report relate to the total number of responses received. Both individual and organisational responses have been counted as one response. The question of whether or not to weight organisational responses differently from individual ones is common to all consultations of this type. However, there are significant challenges involved in developing a robust weighting system. For example if developing a weighting system related to the absolute number of members of an organisation would mean larger organisations would receive a higher weighting than smaller ones. Alternatively if (as some organisations have done in this consultation) an organisation explains that it consulted x of its members should their response be counted as x responses or merely one and so on. In view of these types of challenges it is generally accepted that good practice in consultation is demonstrated by the rigour and transparency with which the analysis has been conducted and a discussion of the difference (if any) between the nature and content of organisational and individual responses (see for example the Cabinet Office guidance on consultations published earlier this year[1]).

In order to ascertain the full range of perspectives that respondents held each proposal offered space for respondents to clarify their responses and/or offer additional free text comments. Respondents were also given the opportunity to make any further comments at the end of the questionnaire. Where these comments related to specific proposals they have been reported on in the section relating to that particular proposal. Some respondents sent in letters and free text documents. A process of 'content analysis' was used to analyse the wide range of qualitative data collected from such submissions and in the questionnaire responses. First the responses to each proposal were reviewed in their entirety to identify recurring themes. These were then grouped into a smaller number of broader themes. These themes were then used to 'code' the data and sort the quotes into categories. Finally, the interpretations and conclusions were shared with Matthew Barker (the colleague who entered the data) for validation.

The findings related to each proposal consulted on are reported in turn with direct quotes taken from the qualitative data to illustrate the comments made and issues raised by respondents. Following this, comments relating to the consultation process overall are summarised briefly. Methodological issues and caveats are then presented. Finally the report concludes by restating concisely the results for the key questions where respondents were asked to agree or disagree with the principles outlined in the consultation document.

[1] Cabinet Office (2006) Code of practice on consultation. London, Cabinet Office

The Findings

Respondents were asked to indicate whether they were responding as an individual or a representative of an organisation. Table 1 below shows the professional groups working with the Foundation's programme to support the regulation of complementary health care and the numbers of responses received from practitioners in these groups.

Table 2 Practitioner responses broken down by profession

Profession	Number of responses
Alexander Technique	24
Aromatherapy	34
Bowen Technique	28
Cranial Sacral Therapy	14
Homeopathy	17
Massage Therapy	42
Naturopathy	3
Nutritional Therapy	53
Reflexology	45
Yoga Therapy	10
Reiki	4
Shiatsu	3

Other classifications used by respondents either to describe themselves or their practice included: acupuncture (n=3); complementary therapist (n=13); healer (n=5); holistic therapist (n=3); hypnotherapist (n=15); manipulative therapist (n=3); physiotherapist (n=8); psychotherapist (n=3); and remedial massage (n=4).

The organisational responses are listed in Table 2 below.

Table 3 Numbers of organisational responses broken down by category

Type of Organisation	Number of responses
Professional Associations	83
Publicly Funded Education Providers	4
Private Education Providers	38
Voluntary Regulatory Bodies	18
Statutory Regulators	5

Please note that the Professional Associations included some which are CAM related such as the Cranio Sacral Therapy Association and the Association of Reflexologists and others which are more generally health related such as the Royal College of Midwives and the British Osteopathic Association.

Some organisations also submitted group letters (FM Alexander Technique teachers), responses from their own consultations (British Naturopathic Association, Forum for Cranial Practitioners) and a collection of pre-prepared standard responses signed by their members (Professional Association of Alexander Teachers).

Q1: Do you agree with the criteria for professions to be regulated by the federal council and what other criteria would you suggest?

71% agreed 11% disagreed 3% didn't know 15% did not respond

In the consultation document it was suggested that professions applying to participate in a federal council would have to demonstrate that they meet certain minimum criteria and that these could include the following:

- the profession having developed and agreed National Occupational Standards, in partnership with Skills for Health;
- evidence of the involvement of lay members and an independent lay chair in their work to date;
- evidence of having made progress towards regulation;
- evidence of having consulted their profession.

71% indicated that they broadly agreed with the criteria proposed. Additional criteria suggested were that:

- the profession has an evidence base, can demonstrate its efficacy and involves a system of diagnosis before treatment;
- practitioners adhere to safety criteria;
- entry to the register requires first degree level or equivalent;
- there is an agreed definition, scope of practice and standard of proficiency for the profession;
- there is a approval system for educational institutions, a core curriculum and a requirement for Continuing Professional Development for all practitioners;
- there is a scheme to ensure that all practitioners meet the agreed standards, an agreed code of conduct and ethics, processes for dealing with complaints and a mechanism for removing people from the register;

- a discrete body of knowledge and/or skills;
- the profession is well established;
- the professional association is financially robust; and
- practitioners have indemnity insurance.

Questions were also raised about how those who were also already on other registers might be dealt with as the following quote demonstrates from the professional association for Midwives:

> *"…The RCM is aware that there are a number of practitioners who might be already regulated, such as midwives or nurses, who might also wish to practice complementary therapies as part of their role. It will be important to make absolutely clear to individuals that they may need to be on different registers by virtue of the area of practice they are using…"* (Case 332)

Key areas of disagreement included:

- the need or otherwise to embrace different traditions within an individual profession; the value of National Occupation Standards;
- the role of lay members;
- the suitability, appropriateness and desirability of the system in general and/or for particular professions.

For example some thought it important that any regulatory system should

> *"…allow[ing] for flexibility and variety of treatment options for profession i.e. different traditions"* (Reflexologist- Case 96)

Others emphasized the importance of demonstrating professional unity:

> *"…We consider that it is vital that each therapy should show a unity of purpose and a majority of organisations committed to a single register. If the register is to be voluntary and yet to have weight and relevance we must avoid any splinter groups or "alternative" registers, which would only confuse the public and not serve the needs of practitioners…"* (Council Member of a Complementary Therapy Association – Case 182)

Some respondents disagreed with National Occupational Standards as a useful means of supporting regulation:

> *"National Occupational Standards – this is a fashionable application of industrial process control to complex and multifaceted human-to-human interactions. A complementary practitioner learns how to BE with a client, within a framework of*

*specific techniques. The external form of this is amenable to a NOS approach, and is only 5% of what actually happens. I guarantee that if a NOS approach to teaching complementary therapies is widely implemented, the likelihood of producing qualified incompetents will increase, because they will think they know what they are doing but actually have no idea whatsoever. The governing body for the profession should be able to opt for the most appropriate means to convey the necessary skills. I submit that the NOS framework is not necessarily appropriate". (*Cranio Sacral Practitioner- Case 13)

Questions were raised by some respondents about the role and function of lay members.

"…whilst significant lay input is a vital feature of all healthcare regulators in the UK, it is not clear from the consultation document why the proposed criteria for aspirant professions should include 'evidence of the involvement of…an independent lay chair' as well as lay members. Indeed, there is no discussion of whether this is compatible with the notion of self regulation or professionally led regulation." (General Medical Council - Case 319)

Q2a&b: Do you think there is a minimum and/or maximum number of professions for the establishment of the council?

The responses were divided regarding the minimum and maximum numbers of professions needed for the establishment of the Council. Most of those who offered a number (n=89) felt that more than three professions would be required to ensure viability, cost effectiveness and meet the critical mass requirements.

To make reasonable progress in accepting the structure by politicians, professionals and members of the public there has to be a recognisable "critical mass" even at the start. This could be 3-5. Practical considerations may override this in terms of the individual professions' ability to achieve the criteria in a reasonable time, but it would be in their interests to do so before statutory regulation seems to be a political necessity. (Hypnotherapist - Case 17)

Some respondents commented that it would also depend which professions because the sizes of the various professions vary hugely:

Consider that the number of practitioners per discipline/total number of potential registrants is more important. Probably 5 or 6 professions would be minimum in order to give a bigger spread of disciplines. For economies of scale,

one would probably be aiming at a minimum target of 10,000 practitioner members. (Reiki practitioner – Case 292)

Several respondents also urged the importance of starting small both as a means of testing out processes and procedures etc and as an enabling strategy:

> *Starting small is a better approach and as it grows encompass other professions and their ideas thus nurturing growth and avoiding to much conflict between larger groups.* (Aromatherapy Practitioner – Case 52).
>
> *Maybe we need 2-3 of the largest or most influential to get the boat moving, assuming that these organizations are furthest in their own self-regulation and unification.* (Nutritional Therapy Practitioner – Case 181)

Similarly the majority of those who responded felt that the goal should be to be inclusive and fair and indeed it was noted that part of the benefit of the proposed federal structure was that it could expand as required:

> *"My understanding of federal is that there is no limits to what they want to do. So no maximum number of professions as this is also limiting us to the various of therapies that are out in the world that are being studied from many civilisations – they all can contribute to peoples health and well being. We have to grow not shut ourselves away.* (Complementary Therapy Practitioner – Case 83)

However many of those who offered a maximum number (n=120) suggested that a Council of more than ten professions was likely to become unwieldy and difficult to manage.

Q3: Do you agree with the proposed fundamental functions and duties of the council?

68 % agreed **11% disagreed** **2% did not know** **19% did not respond**

68% of respondents agreed with the fundamental functions and duties outlined in the consultation document namely:

- keeping a register of practitioners admitted to practise;
- determining standards of education and training for admission to practise;
- providing advice about standards of conduct and performance and administering an appropriate fitness to practise mechanism

- safeguarding the health and interests of patients and the public;
- working in partnership with employers, education providers, professional bodies and other agencies/stakeholders;
- consulting registered practitioners, employers, education providers, patients and the public in making or varying policy, standards and rules;
- having regard to the differing considerations affecting the regulated professions and the individual traditions within the professions;
- having regard to patients and practitioners in all four UK countries – England, Scotland, Wales and Northern Ireland;
- informing and educating practitioners and the public about its work;
- working in partnership with the appropriate forum representing the professional associations.

Several respondents suggested that the first function should be public protection as the following quote illustrates:

> *"The first function should be to safeguard and protect the interests of patients and the public, which should then be followed by the other listed functions. Otherwise, agree. (Case 426, Healthcare Commissioner)*

And as the Royal College of Physicians noted in their response, the:

> *"Fundamental duties of the voluntary council, namely keeping a register, determining standards of education and training, and providing advice about standards of conduct and performance and administering appropriate fitness to practice are the standard regulatory requirements and we agree with these."* (Case 207)

Many respondents were concerned about duplication or overlap with the role of the professional associations:

> *All of these functions would be better dealt with by the representative/regulatory bodies for the various therapies, to prevent duplication of effort and cost (registers) and at a level where people have the expertise to determine the requirements of their particular discipline (education, fitness to practise etc). Key functions for the Federal Council should be oversight of the representative/ regulatory bodies and maintenance of generic educational and professional standards applicable to all therapies.* (Healer – Case 369)

Still others were concerned about protecting a role for schools in standard setting.

Several respondents suggested additional responsibilities for the Federal Council. For example the British Medical Association:

> *The BMA believes there are some additional roles it should play. The council should be responsible for the regulation of claims made by alternative practitioners for the outcome and effectiveness of their treatments. In particular this relates to therapies directed at patients with malignant and terminal conditions, a group who are particularly vulnerable. If a therapist is making unfounded claims about their treatment this should be investigated by the council. It should be a duty of the council to promote high quality research, with the aim of improving the evidence base for complementary medicine in order to help distinguish effective therapies from ineffective.* (Case 31)

And many other individuals and organisations felt that an explicit duty to ensure that practitioners maintain their skills and competence through continuing professional development should be added.

Q4: Have you any comments on the continuing role of the professional associations?

The consultation document suggested that existing professional associations would continue to have an essential and important role, with a strong focus both on the role of the practitioner and developing excellence within the profession. The key functions of these associations would be to:

- promote a strong professional identity;
- advise on the development of standards;
- encourage and facilitate research and development;
- support members in any fitness to practise enquiries.

In addition, it suggested that the professional associations would be free to undertake any other appropriate activities such as:

- providing opportunities for continuing professional development;
- networking;
- award schemes;
- provision of membership services e.g. insurance information;
- provision of therapy clothing and equipment;
- support to practitioners in developing their practice and business opportunities.

It also identified a need for some kind of forum for the professional associations to come together to act as a single and more powerful voice in representing the profession to the federal regulator and outlined two options for achieving this; formal mergers to

reduce the number of professional associations; using the current regulation working groups to continue and adopt this role.

This proposal prompted a huge response both from individual practitioners and professional associations with nearly 70% of respondents offering some comments. In the main, respondents although keen to avoid duplication of roles and responsibilities saw the professional associations as being vital both in terms of preserving the identity and interests of their professions within the Federal Council and outside. An attachment to existing professional associations was expressed both by individual practitioners and perhaps less surprisingly by the professional organisations themselves:

> *I have been with my professional association since qualifying. I would hate to see this relationship deteriorate – I am worried about the future of the professional bodies.* (Complementary Therapy Practitioner – Case 57)

> *"As described this leaves the associations as little more than shells. To leave associations with little more than the provider of clothing (which is optional) and insurance providers (which can be obtained without association input) is an insult to the work developed by associations over the years. Associations must retain their function of accreditation and development of standards."* (Professional Association – Case 59)

And some respondents did not see the need for change and appeared to be concerned that establishing a Federal Council would have consequences for the role and functions of the professional associations as the following quote from a Private Education Provider illustrates:

> *"They should stay as they are. Every therapy must run its own therapy. A federal system cannot hope to carry out the functions of many therapies, it cannot work." (Case – 41)*

In particular concerns were expressed by a significant minority from a variety of stakeholder groups regarding Council taking the lead on standard setting away from professional associations (20% of comments made in response to question 4 related specifically to this issue):

> *The professional associations should have the main say in the development of standards for their therapy, not the council.* (Patient representative – Case 264)

> *"These professional associations need to maintain educational standards that pertain to that individual profession. They need to retain their own registers of competent practitioners and feed into the federal council. Their standards of*

proficiency need to be reflected in the Federation's standards." (Professional Association – Case 302)

"The work of the professional associations is paramount – the Association of Reflexologists has been a fundamental part of my development as a practitioner… The role of the associations is paramount in maintaining the ethos and direction of the development of each therapy. Regulation is an extremely important area but it is not the only one! The Professional Associations, arguing amongst themselves perhaps [!], must be there to ensure that the Federal Body does not regulate just to the lowest common denominator for PUBLIC SAFETY. The public deserves BETTER." (Reflexologist - Case 333)

Many respondents thought that establishing a 'forum' of associations in each discipline had much to commend it.

"I agree with the comments and in particular the need for a Forum of Associations." (Case 65 – representative from an emerging voluntary regulatory body)

"The Reiki regulatory working group is a forum for the professional bodies and has worked well to date. I could see this continuing. Individual professional bodies would need to continue to represent the various styles of practice. The RRNG should have developed the standards for Reiki prior to being part of the council. "(Reiki teacher and practitioner – Case 84)

"Using the Reflexology Forum as a working example, even professions with over 10 professional associations can co-operate to maintain a 'lead body' to oversee, direct and administer many of the functions requiring 'expert' input." (Case 337 – Professional Association)

Although for some disciplines the idea of developing a single voice for the profession was either perceived to be undesirable, impossible or likely to result in other difficulties.

"Although it is more convenient and cost-effective to have a single association representing a profession this can be problematic. Associations can often be hijacked by particular power-groups and are democratic in name only. Allowing different associations to co-exist provides the professional with a degree of choice. Therefore it is important not to over-encourage or coerce associations to merge." (Massage Therapy Practitioner – Case 77)

Furthermore concerns were raised about the implications for those practitioners who are qualified in a variety of different disciplines:

> *"Professional associations are viewed positively here. The more they can network helps support multi-therapy practitioners such as I, where regulation could be overly expensive and complicated to work with. "* (Case 336)
>
> *"There is a need for multi-therapy associations to continue, as well as single therapy ones, for those who have multiple therapy qualifications."* (Case 102)

Still others suggested that a move to a federal council might well even strengthen the role of the professional associations. Nevertheless whether broadly positive or negative regarding the relationship between the professional associations and a Federal Council, many concluded that the establishment of a Federal Council as proposed would fundamentally change the role and functions of the existing professional associations:

> *Were the approach described in this document, to be used, it seems to me that the professional bodies would, effectively, become trade unions, negotiating on behalf of their members. I cannot comment on whether this would be a good thing or not. It would however change their current function quite dramatically.* (Practitioner – Case 70)

Q5: Do you agree the structure outlined would be appropriate for membership of the council?

50 % agreed **21% disagreed** **6% did not know** **23% did not respond**

The consultation document proposed that the federal voluntary council have representation from all member professions, lay members and all four UK countries and that its structure should also ensure that the views of different traditions within any one discipline are given due consideration by the council. It proposed that that the council be made up of:

- one elected practitioner registrant for each profession regulated;
- one lay member for each profession regulated;
- a chair of the council.

And that these should encompass representation from each of the four UK countries and include at least one person with educational expertise.

50% of respondents agreed with the proposed structure and 21% disagreed. Particular concerns included doubt that one elected practitioner representative for each profession would be sufficient, the need for more educators, and that there should be 'common' lay members rather than one for each profession. Some respondents were not convinced that four country representation was essential, respondents expressing this point of view included individuals and organisations from countries other than England. Others suggested an additional element namely the benefit in having representation from other statutory regulatory bodies such as the General Medical Council.

Few respondents agreed that one practitioner from each profession would be sufficient. Some were concerned about cover for sickness and annual leave etc. Others were concerned that it would be impossible for one practitioner to truly represent the profession. Many of the CAM professions embrace different traditions and schools of thought within the same profession which complicates the issue of representation.

> *"The problem with having only one practitioner for each profession regulated is that there are numerous schools within each discipline and, unfortunately, they are invariably at odds with one another…."* (Yoga Therapy Practitioner – Case 19)

> *"I do not see how the composition itself (as outlined in the bullet points) can meet the requirements of the last sentence in paragraph one 'It must also be structured to ensure that the views of different traditions within any one discipline are given due consideration by the council' – currently, we Alexander professionals would require 4 seats on the council to ensure this. "* (Professional Association – Case 72)

Concerns were also raised about representing the particular needs of multi-disciplinary practitioners. Some also suggested that the number of members should relate to the size of the profession:

> *"The structure should take into account the varying sizes of the professions. E.g. should a profession with 20,000 practitioners and 5 professional associations have one council member the same as a profession with 2,000 and 1 association?"* (Massage Therapy Practitioner – Case 77)

The range of parameters such as geographical location, profession, level and type of expertise etc that would have to be taken into account in electing members was highlighted by some respondents:

"This seems one of the trickiest things to implement in practice e.g. how will the possible conflict between choosing representatives by election on the basis of preferences/merit and having to meet geographical criteria, educational competence etc be reconciled? I'd be reluctant to vote for someone purely on a nationality basis, for example." (Complementary Therapy Practitioner – Case 64)

"The structure proposed, with three categories – elected practitioners, appointed lay-members and an independent Chair – is eminently sensible. However, when the structure is overlain with requirements that all four nations be represented there is a serious question of control. If the initiating council is to be built from the bottom up – by appointments from the independent discipline councils – there is no way to demand that there will be a Scot without allocating the duty to appoint a Scot to a particular profession – and there goes their independence. A related, but bigger, problem occurs if requiring every tradition to be represented." (Shiatsu Practitioner – Case 68)

Many respondents appeared to be unclear about whether or not four country representation was required within each profession or merely across the Council as a whole. Some suggested that membership could be rotated around the four countries instead. Finally some respondents suggested that ensuring representation from minority ethnic groups on the Council was more important than ensuring representation from the four countries of the UK.

The four country issue has been managed in the following way by the Health Professions Council[2]. If following the receipt of nominations for election it is clear that it would not be possible to appoint a Council that would meet the home country representation requirement, the Returning Officer may extend the time allowed for the nomination of candidates and take such measures as he considers appropriate to facilitate the nomination of candidates for the unrepresented home country. Following the ballot if the Returning Officer certifies that the home country requirement would not be met, the Council identifies which home country would not be represented and appoints from among all the candidates from the unrepresented home country, the person who received the highest percentage differential vote in place of the person elected to be the registrant member or the alternate member to represent his part of the register unless doing so would remove a person who should be the only alternate member or registrant member from another home country. In that event the Council appoints the candidate from the unrepresented home country with the highest percentage differential vote.

[2] The Health Professions Council (Election Scheme) Rules 2004

Many respondents suggested that education would be insufficiently represented within these proposals and many wanted to include an education member per profession. Ensuring expertise in different levels and types of education was also believed to be important. For example a lecturer in aromatherapy noted that:

> *In view of the varying educational requirements of each therapy and even within one therapy, it might be wise to have representatives at different levels e.g. degree, private diploma, HNC, HND N/SVQ etc* (Case – 7)

In terms of lay members, some were unconvinced of the need for lay members at all; others would have appreciated more information regarding the lay members' role as indicated by this quote from a massage therapy practitioner:

> *I don't understand what the function of the lay member would be. Are these voluntary or paid positions? What requirements would these people fulfil?* (Case 61)

Others were unconvinced of the need for each profession to have its own lay members as the following comment indicates:

> *"I find this section of the consultation document unclear. Surely it is better to have a body of lay members rather than one for each profession regulated. I think it is undesirable for any one profession to have its "own" lay members. To have one lay member for each profession regulated would be to ignore that some professions will be much larger than others. The value of lay members remains the same whatever the profession as they bring a much-needed external view to the proceedings."* (Case 23, Barrister specialising in the regulation of health professionals)

Respondents seemed unfamiliar with the debates going on in regulation more generally about the central role of lay members and contemporary ideas regarding professionally led self-regulation[3] [4].

[3] Department of Health (2006) The regulation of the non-medical healthcare professions. London, Department of Health

[4] Department of Health (2006) Healthcare professional regulation: public consultation on proposals for change, London, Department of Health

Q6&7: Who would you suggest carry out the appointment process for lay members and how should the Chair be appointed?

The consultation document explained that under a statutory system, lay members are appointed by the NHS Appointments Commission but that this would not be an option for a voluntary regulator and therefore to ensure the process is open, transparent and in the public interest, it would be necessary to find an alternative and appropriate agency to carry out this function.

Responses were divided as to the most appropriate agency or body to carry out this role. 28% of respondents either said they didn't know or didn't respond. The most common suggestions were that the professional associations should perform this function (20%), the Prince's Foundation for Integrated Health (13%) and the Federal Council itself (7%).

Caution must be exercised in interpreting the results as many respondents explained that they did not understand the terminology and did not understand what 'lay' meant in this context and what a lay member of a Council might do and why such roles might be needed as indicated in the following quotes:

> *"Hard to say - the use of the word 'lay' troubles me slightly. If you mean non-professionals this could be difficult as all bodies will want as much representation as they can get. I think there might be a problem finding people who understood enough about all the different disciplines to be in a position to regulate them."* (Homeopath - Case 69)

> *"Here again the issue is raised of the definition of "lay". If I am a shiatsu practitioner but know nothing about craniosacral therapy can I be a lay member on council for craniosacral!? This is what makes it rather silly to suggest a lay member for each profession."* (Complementary Therapy Practitioner and Teacher - Case 111)

Although 20% suggested that Professional Associations should appoint lay members it seems that few if any of the professional associations already have a system in place that would enable them to do this effectively:

> *"A tricky point. There are no client organisations that I'm aware of in hypnotherapy for example. The professional organisations could organise such a body formed from lay members of the public, with or without experience of the therapy concerned. It would then be up to this body to elect a representative for that particular therapy. This could also be done for each of the therapies by the federal council. "* (Case - 17)

Issues raised included the need for independence and the dangers of political manipulation and the safeguards that were likely to be required to ensure this:

> *"Before any appointment process there needs to be criteria established by which to vet lay members which includes: a) Their understanding of 'Holism' b) Basis of interest, involvement, & experience of comp therapies. c) Occupational background, including any training in health professions, psychotherapy, etc. d) Any conflicts of interest or adversarial experience with comp med. e) Length of time in study of or treatment by comp therapies. Sources of nominees for lay members: Existing-established comp med patient group organisations and other non-practitioner groups that have an affinity to comp med.* "(Case – 76)

> *"The issue as I see it would be that those interested enough to volunteer the time may be either very enthusiastic clients who've become greater advocates than the practitioners, or else sceptics out to "debunk" the complementary therapy field – neither of which groups are well placed to serve as impartial outsiders!"* (Case 404)

Some felt that the lay members should not be linked to a particular profession and that the appointment process should not be carried out by a body linked to a particular profession:

> *"It is important that the appointment process is done by a body that is not associated to a particular therapy."* (Retired reflexology and aromatherapy practitioner – Case 39)

Other suggestions on process included:

- asking groups such as the Patients' Association for nomination against clear criteria; advertising in business, consumer and health organisations;
- using the same process as the NHS Appointment Commission;
- mimic the process used for the appointment of Governors of NHS Foundation Trusts;
- an independent body such as REACH;
- create an appointments committee of representatives from statutory regulatory bodies such as GMC, GOsC, GCC, GOC etc;
- a publicly accountable body with a strong background in CAM such as RCCM, King's Fund, iCAM, Institute for Complementary Medicine etc;
- an independent recruitment agency; and
- advertising for volunteers from organizations like the "Rotary Club" .

In terms of the appointment of the chair specifically, once again there was a high proportion of "Don't knows" and non responses – 24%. The most popular option was that the chair should be elected by members of the council (35%). Other responses included:

- on a rotational basis from amongst the elected members;
- appointment in consultation with the professional associations;
- nomination;
- an independent national application process; Prince's Foundation for Integrated Health; and
- NHS Appointments Commission.

Q8: Do you agree with the proposed council committee structure?

57% agreed 16% disagreed 3% did not know 24% did not respond

The Consultation document suggested that work of the council could be supported by a number of committees likely to include one responsible for education and training, and three fitness to practise committees: investigation, conduct and competence and health.

57% said they agreed with the proposed council committee structure, 16% disagreed and 27% either didn't know or didn't respond. Professional Associations were more likely to respond than individuals. The main concerns appeared to be a desire to ensure efficiency, reduce bureaucracy and contain costs.

> *"There is absolutely no need for the number of committees proposed. This will lead to unnecessary duplication of effort. 2 committees will be adequate, one dealing with Education and Training and one with 'Fitness to Practise'..."* (Professional Association – Case 81)
>
> *"While committees to support the council are necessary, they should be kept to a minimum to ensure bureaucratic systems/delays and costs are kept as low as possible without affecting the performance of the council."* (Complementary Therapy Practitioner – Case 223)

Several respondents felt that there was too much emphasis within the structure on Fitness to Practice as this response from a professional association exemplifies:

> *"This proposed committee structure is totally unbalanced. The heavy emphasis on 'fitness to practice' is disproportionate to the reality of managing effective self regulation, and could ultimately be stultifying. The following three committees constitute a reasonable balance for a regulatory body: 1. Registration, to determine basic criteria for applicants who have completed a recognized training, and to also determine an APEL route to registration, for applicants who have learned their skills via other means. 2. Education, to determine basic criteria for the delivery of training in a profession. This committee would oversee the accreditation of courses that meet the required criteria, and would also establish workable CPD guidelines. 3. A Professional Conduct committee, to investigate complaints and refer to the appropriate adjudication panel if necessary."* (Case 261)

The GMC remarked that:

> *"We have noted the proposal to establish four main committees, including separate conduct and competence and health committees. Until recently, the GMC had three fitness to practise committees: the Professional Conduct Committee, the Health Committee and the Committee on Professional Performance. Following the implementation of our own reform programme these have now been consolidated into one Fitness to Practise Committee which considers all allegations of impaired fitness to practise. We do not seek to suggest that the GMC model is necessarily applicable to all health regulators, but wish to ensure that you are aware that a different model has recently been implemented elsewhere."* (Case 319)

Some respondents remained unconvinced of the feasibility and appropriateness of having non-profession specific committees for Fitness to Practise and Education and Training and either rejected the proposed structure outright as a consequence or sought further information:

> *"Again, I think this all sounds fine in theory, but I think in practice it will soon grow unwieldy….* "(Counsellor and therapy practitioner – Case 70)

> *"The education and training should remain the responsibility of the individual professions. Unless that control was retained I would not wish to see Reiki joining a federal body."* (Reiki Teacher and Practitioner – Case 84)

As a means of managing the issue of ensuring adequate and sufficient profession specific knowledge, understanding and representation one professional association suggested:

> *"...a principle of appointed secondees from Professional associations to support the work of the committees to ensure the unique professional issues of each profession are fully considered and not diluted."* (Case 309)

Some suggested that there should be additional committees for the following functions and activities:

- registration;
- professional standards;
- finance and resources;
- continuing professional development;
- public relations and communication;
- performance management and governance;
- general purposes; and
- research and development.

Q9: Do you have any comments on the registration of practitioners?

The consultation document explained that the key function of a new federal council for complementary healthcare would be to keep and maintain a register of members admitted to practise. It noted that as with the regulatory model provided by the HPC, the register could allow arrangements for a number of professions with provision for more if required. Once the register is fully established i.e. following any agreed transitional period, entry to the register could be based on other healthcare regulatory models. The final criteria and details would be developed in consultation with the professions to be regulated, and could include that they:

- satisfy the relevant committee of the council that they hold an approved qualification;
- provide evidence that they are in good health, including meeting Government safeguarding requirements such as CRB checks;
- provide evidence of good character;
- satisfy the council that they are safe and competent to practise.

The question of how to define an 'approved qualification' prompted many responses. The importance of ensuring consistency and fairness was emphasised and the need for an APEL (Accreditation of Prior Experiential Learning) route was stressed. There were also a diverse range of views expressed about the role of the professional associations in providing this approval.

Good health as a concept was believed to require further clarification and definition:

> *"I agree with the most of the 'ways of meeting criteria for registration' with the exception of health checks on therapists, this is a grey area, as I know of some therapists that do have life long health problems, that are expertly maintained by themselves, but will never go away despite their excellent care. The said section therefore needs to be defined."* (Nutritional Therapy Practitioner – Case 294)

Concerns were expressed about who should pay for additional checks e.g. CRB – the individual practitioner or their employer.

Many responses from both individuals and professional associations suggested that a requirement to provide evidence of good character would be problematic.

> *"The RCN [Royal College of Nursing] considers that there are significant challenges in assessing 'good character'. Nursing has experience of these difficulties*." (Case 413)

Similarly many respondents requested further information about the type of evidence that could be presented to demonstrate that practitioners are safe and competent to practice and once again the role of the professional associations in ascertaining this:

> *"If practitioners have already been vetted by a professional body, this should be enough."* (Professional Association – Case 345)

Many thought there should be additional criteria including evidence of:

- Continuing Professional Development;
- indemnity insurance; and
- a site visit; and
- a reference from existing registering/professional body.

Others suggested more inclusive approaches:

> *"The only criteria for registrants of a new profession joining an established register for the first time should be that they are/have been practicing lawfully, safely and effectively. Great care must be exercised in the approval process not to exclude clinicians on the basis of their 'qualifications'. The Council should be charged with a duty of making registration as inclusive as possible and consider setting criteria for exclusion instead. E.g. anyone can join the register if they have practiced lawfully, safely and effectively and are willing to accept the*

regulations that the Profession has put in place for the council to administer providing that 'they haven't done anything bad'. (Private Education Provider – Case 137)

"My personal view – registration of practitioners – automatic registration from those members belonging to a professional association forming part of the individual regulatory or proposed regulatory boards and should be overseen by the FC." (Private Education Provider – Case 128)

Or at the very least not duplicating work that had already been undertaken by professional associations and other voluntary regulatory bodies:

"Given NTC currently taking over from BANT – practitioners are having to go through arduous grand parenting scheme to get on NTC register (it's very time consuming etc) It would be hellish to have to go through this again! I would hope that admission to the NTC register would give automatic membership of any federation register." (Nutritional Therapy Practitioner – Case 97)

Managing the registration process itself was also noted to be likely to require complex systems and processes:

"How will information submitted to the Council be vetted? Surely there will need to be assessors from within each field to evaluate applications. Criteria would need to be flexible to allow for different areas covered. It shouldn't have a complexity that might 'put people off' putting themselves forward for registration" (Practitioner Alexander Technique – Case 390)

The importance of learning from other more established regulators was recommended:

"At the first stage of bringing regulation to groups that have not been so regulated, the systems and processes for each of the stages mentioned (i.e. satisfy the relevant committee of the council that they hold an approved qualifications etc) would need to be carefully constructed to reflect the health care area, and to be practical and achievable. It would be useful to discuss this further with bodies such as the Nursing and Midwifery Council, who have developed mature and sophisticated systems, to ensure that processes will enable these objectives to be achieved. The issue of continuing competence and CPD needs to be linked in with initial competence to practice and may exercise the regulatory body considerably" (Professional Association – Case 332)

The implications for practitioners practising a range of different professions was also queried:

"I have a concern that many complementary practitioners list being trained in several disciplines (myself included) but experience shows that it is virtually impossible to CPD in all of them. I would not want to see a registrant being allowed to register in many disciplines as I do not believe that they can maintain fitness to practise in them all. A record of having trained in a discipline would be different to being registered to practice." (Hypnotherapist – Case 35)

The element of these proposals that prompted most comment from both practitioners and professional associations was whether or not the professional associations would continue to have a role in maintaining professional registers and the implications for the sustainability of the professional associations if their role was reduced or constrained.

"Yes but I would still encourage the professional bodies to keep these registers and the federal committee role to be to support them." (NLP Master Practitioner, EFT Practitioner and Trainer, Reiki Practitioner and Researcher – Case 406)

"This is a good idea but would carry a degree of redundancy with the existing professional bodies carrying out these functions. Do they then cease carrying them out, or act on a delegated basis in providing the required proof to the council? I think that once the council had defined a required set of registration criteria that the administration of prospective registrants could be devolved to the professional bodies and final checking and approval carried out by the council. " (Private Education Provider – Case 17)

Q10: Do you agree with the approach as outlined to the accreditation of courses and qualifications?

56% agreed 14% disagreed 6% did not know 24% did not respond

The consultation document noted that approaches to systems of professional accreditation of courses and qualifications within the individual therapies vary. Most of the therapies on the regulatory programme have published national occupational or professional standards (NOS/NPS), acting as a benchmark for practice or are currently drafting standards and will likely have agreed and published these within the near future. It explained that a few therapies have developed core curricula, based on their NOS, to which practitioner-level qualifications can be mapped. These curricula include elements of course/programme and institutional requirements, including assessment

criteria and quality assurance statements. Some of the groups are also working towards developing a single system of professional accreditation and are in the process of consulting their members and other stakeholders.

The consultation document goes on to propose the following as a potential way forward: groups to undertake further work to enable the development of an accreditation system within a federal structure for regulation. The HPC model of accreditation could form the basis for development. First steps could be:

- Groups to work towards consensus about standards of *education and training* across all their therapies (including institutional standards). These standards could form the basis of accreditation.

- Groups who have agreed NOS to use these to develop an agreed framework of *standards of proficiency* for their therapies to include a generic and therapy-specific component.

- Groups to agree a policy on accreditation of courses and qualifications, to include the agreed structures above. The resulting accreditation document could then reflect the therapy-specific requirements within a generic framework for quality assurance. The accreditation document could also specify the requirements and arrangements for institutional and course approval, such as:
    - documents to be provided on application and visits;
    - the approval process;
    - visitor's role and required backgrounds, experience, lay representatives etc.
    - The involvement of other stakeholders such as the Qualifications and Curriculum Authority (QCA) and the Quality Assurance Agency (QAA).

56% agreed with the approach outlined in the consultation document and 14% disagreed.

The main areas of contention included the role of the professional associations and academic awarding bodies; and the feasibility or otherwise of achieving consensus about standards of education and training across professions, and the role and utility of the National Occupational Standards.

> *"There is no reason to stray far from the processes the government has set up in the National Qualifications Framework. The Council should work with Skills for*

Health and QCA to enable schools and colleges of all sizes to run courses leading to qualifications issued by accredited Awarding Bodies or through RBs. It is not courses that need accrediting it is qualifications. An accredited qualification is about having defined criteria for "fitness to practice" based on a proper course and training. Each RB should have standards for the technical education/training in its field and should relate to common agreed standards for professional ethics, client care that are 90% common to all professions. The NOS should be the minimum standard where NOS exist. At present many Diplomas are issued by schools not part of any Awarding Body with no verification of standards. PAs need to monitor and advise schools and colleges in their membership. The proposal replicates work that already is done by Awarding Bodies and others." (Professional Association – Case 254)

"In aromatherapy, there are concerns that the NOS standards are very low starting point – the absolute lowest common denominator." (Complementary Therapy Practitioner – Case 123)

Q11: Do you agree with the role of the visitor and that the professional associations could provide guidance of their appointment?

58% agreed 10% disagreed 7% did not know 25% did not respond

The Consultation document states that quality assurance is key to ensuring that standards of education and training are appropriate and maintained. It explains that professional accreditation of courses and programmes of study, leading to council approval, would be carried out, in a federal system, by a number of 'visitors'. These appointed visitors, would provide the quality assurance report on courses and programmes to the new council, and should include representatives from registrants on the appropriate part of the register, lay representation and those having experience in institutional and course audit. The consultation document notes that this is the model adopted by most healthcare regulators including the HPC. It emphasises that visitors should not, have any connection with the provider institution being approved and suggests that the professional associations could provide guidance on the appointment of potential visitors.

58% of respondents agreed with the role of the visitor and that the professional associations could provide guidance of their appointment. 10% disagreed.

Several respondents were happy with the role but unhappy with the term visitor:

> *"The term 'visitor' should be replaced by a more suitable term such as assessor, verifier or moderator."* (Professional Association – Case 197)

One respondent although agreeing that professional associations could advise regarding the role of the visitor suggested they should only advise for other associations and not for their own. Another suggested that visitors should not come from rival institutions. Still another suggested that the professional associations shouldn't have a role as visitors were expected to be education experts rather than profession experts.

> *"... the appointment of visitors should not need guidance from the professional associations, since it is the generic aspects of course and teaching institution requirements which are primarily under inspection, not the profession specific elements of the courses which should be covered by experts in the specific field. The guidance of the professional associations, therefore, would be more appropriate in assessing the academic content within the inspection visits."* (Acupuncturist Case – 216)

Many respondents wanted more information on:

- the nature of the role; where visitors would come from;
- how they would be appointed;
- what qualifications and experience they would be expected to have; and
- the likely cost and resource demands including time of implementing such a system.

Q12: Do you agree with the proposal for conjoint validation?

57% agreed
8% disagreed
9% did not know
26% did not respond

The Consultation document suggested that where there is opportunity for any conjoint validation with an educational institution (such as a higher educational institution), these should be encouraged and visitors should also be able to sit on the course provider's approval panel, where appropriate.

57% agreed with the proposal for conjoint validation and 8% disagreed. 9% of respondents said they didn't know and 26% didn't respond and even amongst those that responded many said that they didn't really understand the question.

Some respondents reported that conjoint arrangements already exist in some professions:

> *"I agree the International Federation of Professional Aromatherapists is already involved in conjoint validation." (*Aromatherapy Practitioner – Case 396)

The following concerns were expressed:

- the possibility of Higher Education Institutions dominating the process;
- the links between Higher Education Institutions and the Qualifications and Curriculum Authority;
- the possibility of duplicating already robust systems and processes;
- not being convinced that this should be a priority; and
- the possibility of creating a further division between the academic and the non-academic in each profession.

> *"No as this would be virtually unworkable based on the current number of schools in the CAM system. There is already an external validation process that seems to work but whether one method is better than another is another question. Higher institutions generally tend to be knowledge based rather than skills based e.g. law degree holders have to take professional qualifications."* (Complementary Therapy Practitioner – Case 189)

> *We feel this is irrelevant at present. Developing work across the therapy specific groups is the immediate priority and conjoint validation could be diversionary.* (Professional Association – Case 200)

> *"Yes – but I also feel it is important that courses which are not validated by a higher educational institution are not undermined. Not all therapists wish, or indeed can afford the time or money, to gain academic qualifications. I see a real divide coming between the established therapists working with experience and professional intuition, and the newly qualified 'academic' therapists. I can only hope we can all work together and value each others attributes and commitment to the work we do. "* (Practitioner – multiple disciplines – Case 291)

Q13: Do you agree there should be a transitional period to enable the setting up of a new council and register?

75% agreed 3% disagreed Less than 1% did not know 22% did not respond

The consultation document explained that it would be likely that there would be a transitional period to enable the setting up of a new council and register. 75% of respondents agreed that there should be a transitional period and only 3% disagreed. Those who agreed saw it as a fair and appropriate thing to do and were aware of the complex and time-consuming tasks ahead:

> *"Yes I do agree that there should be a transitional period as this would be the fairest thing to do. There is going to be some professionals/therapists that will not be up to the same standards as others and will need the time to upgrade their qualifications. Some courses in FE will take 36 weeks"* (Practitioner – multi-professional, Case 83).

Most of those who disagreed did not support the establishment of the register, others disagreed because it was a voluntary system and therefore thought more flexibility should be possible.

Other issues raised included:

- whether or not there would be a probationary period;
- the importance of ensuring there is a procedure for those who choose to join a register after the transitional period who may be practising overseas or on extended leave of absence; and
- the importance of a transitional period in enabling the structures and systems to be 'tested' and fully developed.

Q14: Do you agree that this should be for a term of not less than two years from the opening of the register?

66% agreed 7% disagreed 2% did not know 25% did not respond

The consultation document proposed a transitional period of not less than two years from the date of opening of the register because this is in line with most of the healthcare professions that have recently gained statutory regulation. It proposed during this time the applicant must satisfy the new council that they have been practising in a safe and competent way, for three out of the five years (full time or part-time equivalent) prior to the opening of the register. It would be up to the registration or education committee in consultation with the profession, to decide on what evidence would be required to show safety and competency. This could include evidence of self reflective practice, audit of practice, case studies and letters from patients or employers. Here, the professional associations could provide valuable support for their members.

66% of respondents agreed that this should be for a term of not less than 2 years and 7% disagreed. Many respondents felt that two years was too short in view of the nature and complexity of the task and the likely challenges for individuals.

> *"However two years is probably insufficient time for a transition period, especially if the profession/s involved are serious about being inclusive. There needs to be sufficient time to account for students already engaged in the existing educational process. They must not be disadvantaged when they eventually graduate. Also, the transition period needs to allow for the agreed accreditation process to be phased in... The changes involved in setting up the structures to support voluntary self regulation cannot be rushed, so some form of transition is essential in order for adjustments to be made. The only way to keep the majority of the profession/s on board, is to minimize the negative elements that accompany changes of this nature , and honestly address problems as they arise, rather than 'gloss' over them in the name of expediency. "* (Professional Association, Case 261*)*

> *"Yes, but two years would be an absolute minimum, bearing in mind my general comments above about career breaks for family responsibilities, and the likelihood of a slow start to the process. Five years might be more sensible, expecting many mothers to think of starting work again when the child(ren) start school."* (Complementary Therapy Practitioner – Case 404)

However a regulatory body which has recently been through this process commented:

> *"…but two years is too long. Experience of the GOsC is that it did not allow for phased receipt of applications as expected – over half applied in the final six weeks. A year is sufficient time for the receipt of applications. But because an application can be lodged only hours before the time closes, a further year may be required for processing."* (Case 403)

Certainly some time for testing the system was advocated by many respondents as was the need for an appeals process:

> *"I think this term needs to be as long as possible. I can't imagine doing more training at the current time for a couple years. People who have gone on these courses did because it was the right thing to do at that time in their life. Putting time constraints on people is not justified, so should be open who at least there needs to be an opportunity to appeal"* (Nutritional Therapy Practitioner, Case 243)

More clarification was requested regarding the criteria for full and part time practitioners:

> *"Yes how does the "three out of five years" practise time apply to part time therapists? Does it mean that part time must add up to equivalent 3 years full time out of a 5 year period – if so practitioners working 50% or less would not be eligible"* (Nutritional Therapy Practitioner, Case 362).

And concerns were raised about inadvertent institutional discrimination in relation to particular groups such as women taking time off for child rearing etc.

Others suggested alternative and in their view simpler systems:

> *"Here is the best and simplest approach – register opens on 1/1/07, everybody who qualified before 1/1/07 automatically qualifies for grandparenting – everybody who graduates after 1/1/07 does not."* (Practitioner – Alexander Technique, Case 86)

> *"Members of existing professional organizations should automatically be entered into the new register if that organization is recognized. I do not understand why a transition period is needed"* (Practitioner – Bowen Technique, Case 33)

Q15: Have you any comments or suggestions for grandparenting during that transition period?

The consultation document explained that some practitioners, currently registered with professional associations in the UK, or unregistered and practising, will want to obtain access to the new register but may not have the required agreed qualifications. They may have a good deal of training, experience and skills and therefore would require an

alternative route of entry. A grandparenting scheme,[5] specifying the form of evidence appropriate for entry, should be put into place. It noted that in a federal system this scheme might vary, as each profession has its own specific requirements though it is envisaged that there will be some comparability of standards and processes. It highlighted that multi-disciplinary practitioners will benefit from consistency of approach across the professions and that this also has the potential to lead to cost savings for practitioners. It also suggested that alternative arrangements could be made for those who do not meet these criteria and that this might involve a test of competence or further 'update of practice' course.

Some disliked the term grandparenting. Many respondents emphasised that the requirements for grandparenting must be inclusive and encourage practitioners to register.

> *"Strategically, the easiest solution is to use a modified form of time served and self- declaration is the least troublesome, and given that this is a voluntary form of regulation, probably consistent with the level of requirement one could reasonably expect. Since it will be possible to continue to practise outside the voluntary framework, it makes sense to encourage registration rather than create a barrier which discourages entry. If in the longer term the register becomes statutory, a higher level of requirement can he introduced for the transitional period."* (Acupuncturist, Case 216)

> *"…There should be two routes to registration to a new regulatory body:*
> *1. Practitioners already on an existing register should be eligible to apply for registration to the new body, providing their registration is a) current, b) there are no professional outstanding/unresolved conduct issues, c) they sign an agreement to practice according to the new body's Code of Ethics and d) they sign an agreement to undertake regular CPD.*
> *2. All other applicants to a new register would go through an agreed registration process, designed to take into account prior learning and experience. There should not be any stipulation relating to the number of years an applicant has been in practise, as this could potentially exclude practitioners. As self regulation is voluntary, the public interest could be compromised if significant numbers of practitioners chose not to register as a result of potentially divisive requirements. …"* (Professional Association, Case 261)

[5] Grandparenting is a term that is often used to describe how an existing practitioner provides evidence that they meet the standards to gain entry to the register. This is sometimes known as accreditation of prior experiential learning (APEL).

Conversely others thought that the success of the system depended on applying high standards:

> *"Much depends on the evidence required. If this is too weak, the process is meaningless. Doctors have to have annual appraisals from their employer – a process that is rigorous and demanding, though the Donaldson report 'Good doctors, safer patients' proposes an even more rigorous and challenging process in future. The goalposts must be set high enough to exclude poor standards and protect the public. "* (Professional Association Case 307)

Others felt that there should be different systems for practitioners at different stages of their careers:

> *"Grand parenting is needed only for those who have been practising for at least a year and do not hold qualifications that meet NOS standards or their equivalents as set by the RBs and agreed by Council. Those recently qualified without such would need to take a form of assessment through their PA as agreed by the RB and Council. Those who have been practising over longer time would need to submit a fairly simple questionnaire/check list (approved by the RB and Council) with supporting evidence, to their PA to show that they are "fit to practise". It would be totally dis-proportionate to require such people to go through an expensive "re-education or evaluation" process* "(Professional Association, Case 254)

Particular concerns were raised about the different educational levels both within and between different professions:

> *"A practical problem is that practitioners have different educational background within one speciality. While both formal education and practical experience should be recognized, a minimum educational standard is needed, which would necessarily mean that some practitioners without the minimum standard of education have to pay more and join some kind of course (correspondence?) during the grandparenting."* (Nutritional Therapy Practitioner, Case 181)

> *"There are people practising as CAM therapists who have attended a ½ day workshop as their only training. To enter the register, practitioners should meet minimum entrance requirements or have to undertake a 'bridging course' to ensure their skills & practice is up-to-date and safe. "* (Reflexology Practitioner, Case 370)

Forms of evidence that could be used to demonstrate safe and competent practise suggested by respondents included:

- detailed case studies;
- financial records;
- oversight of a number of client sessions;
- test of competence;
- interviews;
- evidence of CPD;
- evidence of attending a recognised refresher course;
- letters/feedback forms from clients, or clients GPs;
- records of numbers/frequency of clients over the preceding years;
- CV;
- additional qualifications;
- original qualifications;
- articles written;
- papers published;
- courses devised and executed; and
- shadowing another registered practitioner.

In addition many respondents requested that a 'typical' professional portfolio be produced for prospective applicants, to illustrate the process and standard of evidence they should provide in their own portfolio.

There were mixed feelings regarding the role of client testimonials with many practitioners and professional associations recommending them as a useful part of any portfolio however others were not convinced.

Cost was also a concern:

> *"Grandparenting should not involve costly interviews for APL, costly extra training with costly extra assessments that could effect livelihoods and work prospects.* " (Complementary Practitioner – multi-professional, Case 189)

Many respondents felt that membership of a professional association should guarantee entry to the register. This feeling was particularly amongst those who had already been through what they believed to be a robust and complex process to secure membership to their professional association.

Overall respondents wanted clear and robust criteria which were applied consistently across the UK and recommended learning from the experience of other statutory and voluntary regulators who have been through similar processes. A strong role for the

Professional Associations was articulated in providing practical support, guidance, information and learning opportunities throughout this process.

Q16: Have you any comments on the registration of practitioners who have qualified overseas?

The consultation document identified that there are some qualifications in a number of therapies, such as massage and aromatherapy, which have international recognition. It suggested that the awarding bodies for those qualifications be consulted on the agreed standards of proficiency so that they can map their qualifications to the standard and the proficiency standards will then be used as a benchmark for all overseas qualifications. It suggested that where there is limited knowledge or agreement on standards of proficiency each applicant is assessed separately, using suitable portfolio-based and/or competency testing as necessary. Evidence of character, health and conduct would also be required as would a test of English such as TOEFL (Test of English as a Foreign Language) or IELTS (International English Language Testing Service) to applicants for whom English is not their first language (only for those outside the European Union).

The majority of respondents clearly supported these proposals.

> *"For the public safety and good reputation of the profession any overseas qualified practitioner should be able to show evidence written and practice that they meet the NOS and professional standards and laws associated with that profession. TOEFL (level 6) I believe is essential not desirable. "*(Reflexologist, Case 355)

Issues raised included:

- the importance of learning from other regulatory bodies with experience of these issues;
- that the process must be fair, equitable and transparent;
- ensuring that the assessment progress is rigorous;
- wanting further information on who the assessors are likely to be;
- the need to develop reciprocal arrangements with other countries and the role of the Federal Council in promoting this; the need to confirm the identity of the individual; and
- the possibility and desirability of setting up an 'adaptation' programme.

> *"It is not an uncommon requirement for practitioners to undergo some short period of orientation when transferring skills to another country. A period of 3-6 months depending on the complexity of the therapy would in my opinion be appropriate prior to registration. As most CAM practitioners work independently*

this could be linking with either an educational establishment and/or a network of practitioners who they can observe and be observed by prior to registration. This would facilitate a period of time to orientate skills to the needs of the culture and ethics of the new country." (Private Education Provider, Case 205)

Most respondents reinforced the fundamental requirement for competence in English:

"Proficiency in English essential, even if practitioner will be working with his/her own language group. Knowledge of UK law as applied to practising CAM therapies essential. UK registration should be restricted to practise in the UK." (Healer, Case 369)

However, not all respondents were equally concerned about English language competence:

"Regarding English, there are some excellent therapists who can speak sufficient English to 'get by' and it would be a pity to deprive us of their skills. This would require careful thought. "(Professional Association – Case 423)

"Though an English language test might sound sensible for those in public practice or working within and alongside NHS clinics, there are also those working primarily in minority ethnic and/or refugee communities for whom fluency in the relevant community language is more relevant to their practice than English. I'm sure you'll agree they should be able to get insurance for what may be very valuable community work. I am assuming this would not apply to foreign sportspersons/teams bringing their own therapists with them." (Complementary Therapy Practitioner, Case 404)

Some other measures of competence in English were also suggested:

"Other English language qualifications should be accepted, for example practitioners from Commonwealth countries may have O level English language even if English is a 3rd or 4th language" (Nutritional Therapy Practitioner, Case 373)

Others also queried the distinction between the language skills expected of EU and non-EU practitioners:

"I know the reasons behind but cannot understand the practicality of not testing English language skills for people from EU countries. It is just as important that a practitioner safely communicates whether they are from e.g. Spain or Germany (EU) or Mexico or Peru (non EU)" (Practitioner – Alexander Technique, Case 390)

Q17: Do you have any comments on continuing professional development (CPD)?

In the consultation document it was stated that all healthcare practitioners need to maintain, develop and update their skills constantly so that they can continue to practise safely and competently. This includes the need to keep abreast of new research and development in their field and to pursue excellence of practice. As many complementary practitioners work in private practice, they often do not have the professional development support offered by large structured organisations such as the NHS. A new council will need to be aware of this when devising their mandatory criteria for CPD and include, where possible, flexible and inexpensive options in their evidence criteria. This should, however, ensure that the registrant has maintained the required standards of proficiency to continue their registration. It was suggested that the education and training committee would develop a CPD standard, which all registrants would be required to meet for re-registration. Given that many of the professions practise outside large institutional structures, many on their own, some guidance on supervision or mentorship and self reflection of practice may well be required. It might also be useful to include a number of hours of learning with others as a requirement for CPD.

Many of the professional associations already have expectations that members should undertake CPD and some respondents – both individual practitioners and professional association representatives – suggested that CPD should remain the responsibility of professional associations and education providers rather than the regulator.

> *"Implementation and certification for CPD should be the responsibility of the professional associations, to a set of criteria laid down by the council, and should be compulsory for continuation on the register."* (Nutritional Therapy Practitioner, Case 73)

> *"CPD should be run by professional associations and verified by lead bodies such as the Reflexology Forum. CPD should be mandatory as part of registration for VSR. "* (Case 211, Professional Association)

Concerns were expressed about the implications of linking CPD to formal course attendance.

> *"Whilst this [attending courses] is important, Individuals who are unable through family ties, parenthood, caring for ailing friends, neighbours or relatives, or experiencing their own challenges or illness must not be victimised or made to feel less important because they do not attend "courses" etc. "* (Patient Representative – Case 36)

Nevertheless a strong commitment to CPD being mandatory and a view that compliance should be rigorously audited was evident in the responses. Opinions varied as to the relative merits of multi-disciplinary CPD, learning with others and individual reflection on practice.

> *""Would be concerned with practitioners just using reflective tools. A combination of reflection/ audit and recognised training days should be used. The professional associations should ensure access to training is achievable and within resources for independent practitioners."* (Healthcare Commissioner, Case 213)

Many respondents felt that supervision and mentorship was extremely important.

> *"This is very good. We agree that the complementary practitioner working alone would need support/mentorship and supervision. Would evidence of this be compulsory? "* (Healthcare Provider, Case 257)

> *"These suggestions are heart-warming. Group support, mentorship, reflective practise and self-care are so, so important and often so sadly neglected. I think they are essential components of CPD and more important than gaining new techniques."* (Complementary Therapy Practitioner, Case 291)

Those practitioners engaged in more than one profession were particularly concerned about cost and flexibility as this quote from a practitioner using Bowen Technique, aromatherapy and reflexology demonstrates:

> *"Bowtech currently require 16 hrs CPD. This is both achievable in terms of cost and time to the therapist and from personal experience extremely useful. If professionals, such as myself are qualified in a number of techniques, more than 16 hrs CPD would not be achievable"* (Case 14)

However other respondents suggested that it was vital that practitioners were updating in all of the professions and techniques they were using:

> *"Therapists should undertake a minimum amount of CPD specifically relating to each therapy for which they are on the register. This may seem hard for multi-disciplinary practitioners, but it is necessary for the protection of the public. The minimum amount should be set by each therapy body, since it may be different for different therapies."* (Practitioner – Bowen Technique, Case 195)

The importance of 'core' courses was also highlighted. However questions were also raised about whether or not it was appropriate to have the same CPD standard for all of

the professions. Respondents from rural areas also highlighted the importance of access although there was also an acknowledgement that technology was beginning to assist in helping practitioners in remote areas keep up to date.

Once again respondents suggested the importance of learning from the experience of other regulatory bodies with long established systems of CPD such as the Nursing and Midwifery Council.

Overall respondents urged that any standard for Continuing Professional Development should be realistic, achievable, flexible and straightforward.

Q18: Do you agree that the new council should consider advanced or specialist-level practice?

53% agreed
17% disagreed
7% did not know
23% did not respond

The consultation document explained that the new federal council will have agreed standards of proficiency for each of the therapies, which will form the core requirement for all practitioners to gain and maintain registration. The national occupational/professional standards (NOS/NPS) are a good starting point for the development of standards of proficiency. They are similar as they both describe the standards required for practice and are written as competency outcomes. However, NOS/NPS are broader in their scope and include all elements of practice, including, in many cases, continuing professional development (CPD) and specialist practice standards. Standards of proficiency, on the other hand, describe entry-level or baseline standards i.e. those standards which would be the minimum requirement for safe and competent practice in a therapy. They would be a benchmark for registration and re-registration, though they would not necessarily describe standards of excellence.

It suggests that advanced or specialist-level practice is something which the new council might consider (as are some of the statutory health regulators). This may well be something on which the professional associations could be engaged in advising and developing.

53% agreed that the new council should consider advanced or specialist level practice and most of these although supportive in principle suggested that this should be a later priority and was likely to be a highly complex activity.

"Council should be up and running before serious consideration is given to advanced/specialist level practice." (Professional Association, Case 431)

"The issue of specialist or advanced practice is a complex one, and would require additional consultation with the professional groups involved. This is an area that has been extensively debated within nursing and midwifery and remains controversial. In terms of complementary healthcare, first the need is to clarify the various sections of practice, agree on a basic public protection regulation and publish this will be the priority. Though specific or specialist areas exist within the domain of complementary medicine, Advanced practice does not, and therefore further work and a consideration of the effect on the area of practice would need to be considered. " (Professional Association, Case 332)

Some of those who disagreed thought such developments should remain within the domain of the professional associations:

"No. The responsibility of a regulator is to identify 'adequacy'. The pursuit of 'excellence' is a proper concern of the PAs, but the two should not be confused. Even if there is strong support for such 'advanced' or 'specialist' recognition, it should not be allowed to delay the initiation of the federal regulator. Advanced classes can come later." (Professional Association and Private Education Provider, Case 418)

There was also some evidence of disagreement and confusion in the responses regarding whether or not these terms would be used to describe different 'higher' levels of practice or specialist areas of practice.

"Yes I feel passionately about this. Areas like Cancer, Mental Health, Children and Sports NEED therapists who want to do well and exceed standard training – like a 'consultant therapist' level" (Practitioner in Bowen, Massage and Reflexology, Case 411)

There also appear to be profession specific differences with regard to the criteria that could be used to determine such awards.

Others felt that any consideration of specialist and advanced practice would be a negative development:

Q19: Do you agree with the proposed composition and functions of the education and training committee?

57% agreed 15% disagreed 4% did not know 24% did not respond

The consultation document explained that it is likely that, within a federal system of voluntary professionally led regulation, the education and training committee would have a similar structure and function to those within statutory health regulators. It suggested that the Education and Training Committee should consist of one registrant from each of the professions and at least one lay member who has the requisite knowledge and skills to regulate education and training. The chair should be a member of the council. It said that the key function of the committee should be to ensure that the registrants have the education and training required to do the job safely and competently. This would entail advising the council on:

- general standards expected within education and training;
- threshold standards of proficiency for entry to register;
- the approval process for courses and qualifications (including institutional approval); and
- standards for CPD.

It suggests that it would be likely that the education and training committee would need to form limited life sub-groups to develop and advise on some or all of the above, particularly in the early days. It might also be necessary to form a separate group responsible for the registration of practitioners who would work closely with the education and training committee, the health committee and the conduct and competence committees. There should be separate professional advisory groups (in a similar model to those proposed by the Herbal Medicine Regulatory Working Group), which will be separate from the main committees but will provide expert profession-specific advice to the main committees (including education and training) and the federal council. These groups may well report to council and its committees through an umbrella body (i.e. Professional Group Advisory Committee).

57% of respondents agreed with the proposed composition and functions of the education and training committee, 15% disagreed and the rest (28%) didn't know or didn't respond.

Concerns raised included the differences between and the likely impact on the nature, standards, content, style and level of education across all of the professions:

"Some professions require about 20 hours of training, others require about 2000. Therefore I suggest separate professional committees for education and training. Also some professions have no entry requirements for trainees while others demand A levels. Qualifications of dieticians, occupational therapists and speech therapists are comparable. This is not the case in complementary and alternative therapies" (Nutritional Therapy Practitioner, Case 373)

Many of the professional associations suggested that this should remain in their domain:

"We do not agree with this statement. As already answered elsewhere accreditation must remain with the experts i.e. the associations. The suggestion as described within the statement is not managerially possible except by the creation of an enormous bureaucracy which is totally unacceptable to this association. " (Professional Association, Case 59)

The proposed membership of the Education and training committee also prompted debate around the following issues:

- How many members there might be and how they would be selected
- How long members would serve
- Whether or not committees should have lay members?
- Whether or not training providers would be included as part of the separate professional advisory groups; and
- The role of, links with and representation of universities and other academic bodies.

The British Medical Association proposed that the membership should include a qualified medical practitioner. Others were concerned about the workload for Council members. Concerns were also raised about developing an unnecessarily unwieldy bureaucracy.

Q20: Do you agree that provision should be made within the register to accommodate professionals who are using their professional skills in some capacity, but are not involved in patient contact?

66% agreed 10% disagreed 2% did not know 22% did not respond

The consultation document explained that the public are entitled to expect that people on a register are competent, up to date and fit to practise. This would also apply to practitioners involved in education and research. In future, there might be arrangements for members to maintain their registration in a non-practitioner capacity so that they would maintain some of the benefits this might afford – such as conference admission, admission to specialist libraries etc. This would allow some continuity for practitioners who might be taking a career break and who may be unable to maintain all CPD requirements for re-registration. This would necessitate that the new council maintains different levels of registration. However, it should be made clear to the public what the level of registration means in practice and that it would be unprofessional for a member to advertise him- or herself as a registered practitioner if they had not met the full requirements for registration.

66% of respondents agreed that provision should be made within the register to accommodate professionals who are using their professional skills in some capacity but are not involved in patent contact and the most commonly cited examples were teachers and researchers. Although some respondents expressed their unease at teachers who taught without having any patient contact:

> *"I agree that some provision should be made however I think it is important that professionals that are in education should be made to carry out some hands on therapy time to keep their skills to a certain level. If you are teaching full time you loose the hands-on and this is so important for experience for yourself and also to impart to your students. This should also be monitored and not just acceptance of word given. Further proof should be provided, even a work placement required to be set up by the committee specific for this in all professions.* "(Complementary Therapy Practitioner, Case 83)

Other categories thought to be worthy of further discussion were people on parental leave, sick leave, sabbaticals, practising abroad or retired.

Suggestions included having a different category of entry e.g. associate, allowing such individuals to pay a reduced fee, and ensuring those who wanted to go back into practice undertake some sort of refresher course.

To avoid confusion some respondents suggested that these 'associate', 'inactive' or 'non-practising' entries should not be available to the public:

> *"Certainly for those engaged in education or research – for those on a career break then some form of refresher course and re-registration should be mandatory before going on a public register. The inactive register should not be*

made as public or it will lead to confusion. "(Retired GP and Therapy Practitioner, Case 130)

Some of those who disagreed with having different categories of registration advocated this as a means of keeping the Register simple:

> *"People should either be involved and register or not. It would be confusing to have different levels of registration and involve more work in regulating this"* (Professional Association, Case 245)

Others emphasised the core role of the register as a tool of public protection:

> *"The register is supposed to be for public protection. If the therapist has no patient contact why be on the register? This could upset others who are paying a large sum of money to meet all the standards and be insured. Perhaps this question needs to be more explicitly explained – the therapist is either current in practical skill and knowledge or they are not and therefore should not be on the register but there should be a place for retired therapists especially those who work in the voluntary sector and earn no money from the profession."* (Practitioner Bowen Technique and Reflexology, Case 189)

> *"We note the suggestion that it may be possible to make arrangements for members to retain registration in a non-active practitioner capacity. In some ways this mirrors the GMC's own proposals for introducing the licence to practise alongside registration. Care will need to be taken to ensure that there is clarity for the public regarding the privileges attached to different types of registration status. "* (Regulatory Body, Case 319)

Q21: Do you have any comments about fitness to practise procedures?

The consultation document explained that the various procedures used by healthcare regulators to determine a practitioner's fitness to practise have been the subject of attention over the past few years. Many of the existing regulators have already made changes and it is likely that even more radical changes will be proposed by Government in the future. It suggested that any new regulator, statutory or voluntary, will have to take account of these changes and gave the HPC as an example. The HPC has three 'fitness to practise' committees which all have registrant and lay members:

- **The conduct and competence committee** deals with cases about misconduct, lack of competence, and convictions and cautions;
- **The health committee** deals with cases where the health of the registrant may be affecting their ability to practise;

- **The investigating committee** deals with cases where an entry to the register may have been made fraudulently or incorrectly.

The consultation document also noted that consideration would need to be given as to how fitness to practise procedures would apply to practitioners registered on more than one part of the register.

The majority of respondents (88%) made comments regarding the Fitness to Practice procedures outlined in the consultation document. Such comments generally related to:

- concerns about the fairness and transparency of procedures;
- whether or not there would be an appeals process;
- the importance of learning from other regulators; and
- the need for consistency with other professions.

The number of committees also prompted debate. Many respondents suggested that the consultation document proposed far too many committees overall and too many committees for the wrong sorts of things. Some also indicated that depending on the nature of the complaint more than one of these committees might need to be involved.

> *"We question why education, a huge area, should be served by a single committee whereas three committees are required for 'fitness to practise' – cases of non-fitness to practise are relatively rare and surely one committee could deal with all this work. In our alternative proposal most of this work would be done by the regulatory bodies for the individual therapies – as it will need to be in any case – and the Council would require two slimmer committees to set and maintain generic standards.* "(Professional Association, Case 369)

> *"We have noted the proposal to establish four main committees, including separate conduct and competence and health committees. Until recently, the GMC had three fitness to practise committees: the Professional Conduct Committee, the Health Committee and the Committee on Professional Performance. Following the implementation of our own reform programme these have now been consolidated into one Fitness to Practise Committee which considers all allegations of impaired fitness to practise. We [the GMC] do not seek to suggest that the GMC model is necessarily applicable to all health regulators, but wish to ensure that you are aware that a different model has recently been implemented elsewhere."* (Case 319, Regulatory Body)

Respondents debated whether or not there would be a need for profession specific committees and/or membership from each profession on each committee:

"There is a need to ensure that these committees are structured so that the unique nature of each profession is fully considered. We must not homogenise all complementary professions. This is seen as a potential risk of federal regulation by the professions. Including full involvement of each profession and its professional associations in the working committees is essential to mitigate this risk." (Professional Association, Case 309)

Some concerns were raised regarding the potential for inappropriate discrimination particularly in relation to the proposed Health Committee. This was also echoed in some of the responses to Question 16 and the requirement for the practitioner to be in 'good' health in order to register.

Some concerns were also raised about the implications of being registered on more than one part of the register:

"The RCN has concerns about issues of fitness to practise when a practitioner is registered on more than one part of the register. For example: any generic code of conduct will be relevant to all practitioners." (Professional Association, Case 413)

"A practitioner could be registered on more than one part of the register and be unfit to practise massage for example because of some physical incapacity (which may be temporary), but fit to provide nutritional therapy." (Nutritional Therapy Practitioner, Case 327)

Other issues that arose included the role of the professional associations and whether or not the practitioner should have a right to anonymity during Fitness to Practice Procedures.

Q22: Do you believe that a federal council will be more likely to be recognised by statutory healthcare regulators, government agencies and other organisations than a number of individual voluntary regulators?

62% agreed 11% disagreed 7% did not know 20% did not respond

The consultation document stated that a federal structure will be more likely to be recognised by statutory healthcare regulators, government agencies and other

organisations than a number of individual voluntary regulators. The new council would be responsible for negotiating with relevant agencies for formal recognition.

62% of respondents believed that a federal council will be more likely to be recognised by statutory healthcare regulators, government agencies and other organisations than a number of individual voluntary regulators and only 11% disagreed. Indeed for many respondents it appeared that this recognition was why they were pursuing the Federal Council approach:

> *"Hopefully! Without such recognition there will be very little point in any individual paying any fee to join the Register."* (Professional Association, Case 254)

Some qualified their agreement saying that it would be dependent on how actively the Council promoted itself and the resources in terms of time, funds and staff available for it to do so. In general supporters suggested that a key feature would be achieving a 'critical mass'.

For many of those who disagreed, their disagreement was related to the federal nature of the proposed council:

> *"No I do not believe this would be the case. Establishing a therapy specific voluntary regulatory body would be the mark of a mature profession and enhance its credibility. Doing so along with a number of others does not add to this.* "(Case 396, Aromatherapy Practitioner)

Others felt that other factors came into play such as:

- the regard in which each of the professions is held by the public;
- a belief that regulation is an essential aspect of being a profession;
- the role of personal recommendation in how people choose CAM practitioners; and
- the person's actual experience of the CAM profession and the skills of the practitioner.

Q23: Have you any comments relating to the cost to practitioners of registration?

The consultation document explains that as in the statutory sector, a federal voluntary regulatory structure would be funded primarily through initial registration and annual subscription fees. The costs of registration are a concern to all practitioners. However, the eventual registration fees cannot be estimated at this stage as there are a vast number of variables involved. A comparison of the UK statutory healthcare regulators shows that there are economies of scale as the number of registrants increase. For

example, in 2005 registration with the General Chiropractic Council, a single regulator, cost chiropractors £1,000 per annum, whereas registration fees with the HPC (a federal regulator, regulating a larger number of practitioners) was £60 per annum. This would suggest that the per capita costs for practitioners will be significantly lower under a federal structure than a single profession regulatory structure.

73% of respondents made comments relating to the cost to practitioners of registration. The vast majority of these related to affordability. Other commonly raised issues included whether or not multi-registered practitioners should only pay one fee, the implications for the future of the professional associations, what registrants would get for their money and whether or not there would be differential fees for those who worked part time or were on maternity leave, or newly qualified etc.

In general individual respondents seemed to have a potentially unrealistic view of the likely costs of running such a system for example most respondents suggested a fee of under £100 per annum.

Most respondents appeared to see cost as a huge factor in their support for a federal rather than a uni-professional regulatory structure:

> *"Per capita cost 'reduction' supports argument for an overarching federal structure".* (Case 378, Professional Association)

> *"There must be significant financial advantage of a federal structure for voluntary regulation across the profession. If the Council makes use of the existing expertise and in-place systems of the Lead Bodies and professional associations with regard to administration of qualifications, accreditation, external verification and CPD the costs to the registrants can be minimised. The cost to the Council would likewise be significantly reduced and the efficiency and effectiveness of the service will be maximised."* (Case 337, Professional Association)

Indeed successful implementation is potentially extremely vulnerable in relation to both actual costs and practitioners' perceptions of cost:

> *"If entry costs are too high, it becomes self-selecting and thereby not representative of all practitioners, as only those who can afford to become registered will do so. In which case, the federal council will not be truly a voice for its associations and their members and will not be properly supported, and then is in danger of becoming an exclusive club."* (Case 433, Nutritional Therapy Practitioner)

"Costs can be an issue whilst you assume that costs could be lower with registration through the FC. I cannot see that we would then stop subscribing to our Professional association as this provides a personal feedback and support through our professions newsletters and practitioner network who would fund this the Federal Council!" (Case 342, Practitioner Bowen Technique and Reflexology)

"Regulation will not succeed if it is too expensive. Complementary therapists are different from many other regulated professionals, because many work from home, many work part time, and few are well off. Registration fees need to be in the £50-£150 range, and there need to be tangible benefits from registration, or people will not sign up…" (Case 322, Professional Association)

"We believe the costs of running a Federal Council have been severely underestimated, and that such costs will be in addition to, and not instead of, professional association fees. We see no reason why professional associations and single regulatory bodies would voluntarily relinquish the registration of their members and their professional fees to a Federal Council, when this is their main source of income." (Voluntary Regulatory Body, Case 421)

Q24: Do you agree with the principle of establishing a voluntary federal regulatory body for complementary healthcare professions?

68% agreed 14% disagreed 3% did not know 15% did not respond

The consultation document explained that the establishment of a federal voluntary regulatory body will not prevent individual professions pursuing a single voluntary regulatory body, if they consider that to be their preferred option. It will be possible for a federal regulator to exist alongside individual regulators of other professions. The federal body will have the capacity to include other professions at a later date.

68% of respondents stated that they agreed with the principle of establishing a voluntary federal regulatory body for complementary healthcare professions, 14% disagreed and the rest either didn't know or did not respond. The following were typical of the comments made in support of these proposals:

"First rate idea." (Case 3- Patient representative)

"I believe strongly that it is by far the most constructive way forward. " (Case 123- Complementary Therapy Practitioner)

"We can see the public and financial benefits proposed by such a federal body. …" (Case 184 – Professional Association and Private Education Provider)

A large proportion of those who did not agree with the principle of establishing a voluntary federal regulatory body for complementary healthcare professions were Alexander Teachers and Homeopaths. Those who disagreed usually stated that they would only support uni-professional, statutory regulation. For example the following response from a Homeopathic Private Education Provider contains common features with most of the responses from individual homeopaths, their professional associations and their education providers:

`"We feel that Homeopathy stands out from the others professions currently participating in the Princes Foundation for Integrated Health regulation programme. We agree with the House of Lords Report (2000) that Homeopathy belongs in Group 1 with Acupuncture, Chiropractic, Herbal Medicine and Osteopathy and we believe this is the public's perception too…." (Case 422)

The issue for Alexander Teachers seemed to centre more on the inappropriateness of their classification in this consultation process as CAM practitioners or indeed health professionals as this group letter indicates:

"We are FM Alexander Technique teachers; all certified graduates of STAT approved training schools in the UK, the majority of us also current members of STAT. We are writing in response to the consultation document:" Exploring a Federal approach to Voluntary self regulation of complementary medicine". In our practices we have not treated our pupils nor claimed to cure ailments. After a sufficient number of lessons and as a result of learning to use themselves according to their design a pupil can often help themselves to overcome habitual patterns of thought and movement that have caused or exacerbated certain conditions and problems, some of them acute. It is this indirect result of having Alexander lessons that has led to the AT's frequent inclusion in directories of Alternative health and such like. Although it is hard to classify it does not mean that the AT should continue to be erroneously defined. Alexander teachers have always been in the business of education and re-education, teaching a self help method. We strongly oppose the inclusion of the AT in any regulation that attempts to categorise, confuse, identify or conflate the AT with any other discipline, including but not limited to medicine, psychotherapy, new age practice, religion, massage, bodywork, or energy work. For this reason we

oppose our inclusion in a group as envisaged in the creation of a federal regulator of complementary health care. STAT already demonstrates self regulation by maintaining professional training requirements, codes of conduct and established procedures of ethical complaints of its members. The signatories of this letter oppose federal regulation of the FM Alexander technique or of STAT certificated teachers of the Alexander Technique. Although we have had access to the consultation questionnaire it would be misleading to respond through its questions as they appear to be written for therapists whereas we are teachers, of the FM Alexander Technique. "

Concerns were also raised about whether or not a voluntary system would truly protect the public:

> *"It is agreed that the 'Regulation of Complementary Healthcare Practitioners will help protect the public by ensuring that practitioners meet agreed standards of practice and competence', However, there exists a concern that those Complementary Healthcare Practitioners who practice according to agreed standards would sign up to a voluntary structure of regulation whilst those that do not meet the standards will not. This problem would be overcome by statutory regulation, as with all other recognised, NHS funded practitioners."* (Commissioner of Healthcare – Case 29)

And about the federal structure itself such as:

- its complexity;
- the strength of 'voice' and control that would be permitted for individual professions within such a structure; and
- that the proposed structure is too heavily influenced by structures designed for existing health professions.

Q25: Have you any comments on the proposed timescale?

The consultation document explained that a shadow regulator would be established within the lifetime of the Foundation's current regulation programme i.e. by April 2008 and offered the following timescale for consideration.

May to July 2006	Consultation
August 2006	Independent analysis of responses
September 2006	Publication of consultation results and recommendations
October 2006 to December 2007	Developing arrangements for a voluntary shadow federal council

December 2007	Establishment of the shadow council
January to March 2008	Public awareness campaign

The majority of the respondents thought the timescale too short and that in particular more time should be allowed for raising public awareness as the following quotes illustrate:

> *"Looks ambitious to me given different stages of development in 10 therapies included."* (Case 46, Naturopath)

> *"The Shadow Council will need, more than any statutory body, consensus and good will to support it. We suspect that a protracted PR campaign aimed at the professions to be regulated and others involved in CAM will be needed to obtain that support. History has demonstrated the down side of regulation across a range of professions and the establishment of a Shadow Council can be expected to be met with suspicion if not actual hostility. The winning of hearts and minds will take time. Establishment without consensus will set up long term, possibly infinite, animosity."* (Case 119, Professional Association)

Any other comments?

Respondents were given the opportunity to make any further comments at the end of the questionnaire. Where these comments related to specific proposals these have been reported on in the section relating to that particular proposal. Some respondents used this space on the consultation document as an opportunity to congratulate the Foundation on the quality of the consultation document and the consultation process and expressed their pleasure at being consulted.

Other comments which did not relate to specific proposals included:

- issues around the method used for this consultation for example some respondents who were unfamiliar with the debates about regulation found some of the concepts and language used difficult to understand;
- not all practitioners have access to the Internet;
- a perception that timing may have influenced the response rate as it occurred during the holiday period, and the timescale meant that it could not be publicised sufficiently in the professional association journals and newsletters; and
- how the results would influence any action the Foundation is likely to take.

Methodological issues and limitations

As mentioned in the introduction above, the percentages presented in the report relate to the total number of responses received with both individual responses and organisations being counted as one response. As required by commonly accepted recommendations for best practice in consultation further analyses and cross tabulations were undertaken in order to ascertain the difference (if any) between the nature and content of organisational and individual responses. This demonstrated that the general trends are similar in both individual and organisational responses to the fundamental questions. For example, the responses to the first question "*Do you agree with the criteria for professions to be regulated by the federal council and what other criteria would you suggest?*" are outlined in Table 3 below.

Table 3 % Responses to question 1 broken down by category

Category	Agree	Disagree
All groups	71%	11%
Patients	62%	15%
Health Professionals	83%	1%
Members of the Public	57%	29%
Professional Associations	80%	7%
Private Education Providers	68%	11%
Emerging Voluntary Regulatory Bodies	67%	17%

However when the analysis was conducted for individual professions/therapies the overall percentages did appear to mask some variation for example 89% of nutritional therapists agree but only 29% of Alexander Teachers agree.

Similarly variation is evident in the responses to question 24 *"Do you agree with the principle of establishing a voluntary federal regulatory body for complementary healthcare professions?"* as illustrated in Table 4 below.

Table 4 % Responses to question 24 broken down by category

Category	Agree	Disagree
All groups	68%	14%
Patients	62%	15%
Health Professionals	81%	11%
Members of the Public	71%	29%
Professional Associations	70%	17%
Private Education Providers	63%	21%
Emerging Voluntary Regulatory Bodies	50%	33%

Once again these overall percentages do appear to mask some variation between professions because for example 88% of massage therapists but only 53% of homeopaths agreed.

Summary

The consultation took place during the summer of 2006. The consultation document and questionnaire was developed by the Prince's Foundation for Integrated Health and the responses were analysed by an independent consultancy company with experience of undertaking consultations with a wide range of regulatory bodies.

438 responses were received from individuals and organisations. Responses included representation from individuals and/or organisations from all of the therapies associated with the groups currently working with the Foundation's programme.

The responses indicate a clear mandate to pursue the federal approach.