hcpc health & care professions council

Consultation on the Standards of Proficiency

Analysis of responses to our consultation on the Standards of Proficiency and our decisions as a result.

Contents

1. Introduction

About the consultation

1.1 We consulted between Wednesday 17 June and Friday 30 October 2020 on proposed changes to the standards of proficiency for all 15 professions on the HCPC Register.

1.2 We informed and engaged a wide range of stakeholders about the consultation including professional bodies, employers, trade unions and education and training providers. We also advertised the consultation on our website and on social media.

1.3 We would like to thank all those who took the time to respond to the consultation. You can download the consultation document and a copy of the responses from our website: https://www.hcpc-uk.org/news-and-events/consultations/2020/consultation-on-the-standards-of-proficiency/

About us

1.4 The Health and Care Professions Council (HCPC) is a statutory regulator of healthcare and psychological professions governed by the Health Professions Order 2001. We maintain a register of professionals, set standards for entry to our register, approve education and training programmes for registration and deal with concerns where a professional may not be fit to practise. Our role is to protect the public.

1.5 We regulate the members of 15 professions:

– Arts therapists

– Biomedical scientists

– Chiropodists / podiatrists

– Clinical scientists

– Dietitians

– Hearing aid dispensers

– Occupational therapists

– Operating department practitioners

– Orthoptists

– Paramedics

– Physiotherapists

– Practitioner psychologists

– Prosthetists / orthotists

– Radiographers

– Speech and language therapists

About this document

1.6 This document summarises the responses we received to the consultation, and our decisions as a result.

- Section two explains how we handled and analysed the responses we received and provides the overall statistics relating to the responses.
- Section three provides an executive summary of the responses we received.
- Section four adopts a thematic approach and outlines the general comments we received on the draft standards document.
- Section five outlines our responses to the comments received, and any changes we will make to the new revised standards for all professions we regulate as a result.
- Section six lists the organisations which responded to the consultation.

1.7 In this document, "we", "us", and "our" are references to the HCPC; "you" or "your" are references to respondents to the consultation.

2. About the standards of proficiency

2.1   The standards of proficiency are the professional standards that we consider necessary for the safe and effective practice of each of the professions we regulate. They describe what professionals must know, understand, and be able to do at the time they apply to join our Register and in order to remain on our Register.

2.2   The standards of proficiency play an important role in public protection. They set out our expectations for the professions on our Register and explain to members of the public what they should expect of a HCPC registered professional. When a professional applies for or renews their registration, or if concerns are raised about their fitness to practise while they are registered with us, we use the standards of proficiency to check whether they have the necessary knowledge and skills to be able to practise their profession safely and effectively.

2.3   This means that the standards of proficiency are the 'necessary' or 'minimum' standards that we consider to be required for safe and effective practice. The standards therefore do not set out best practice for that profession and should not limit a registrant's ability to provide the best care they can.

2.4   The standards of proficiency complement our other standards, such as our standards for conduct, performance, and ethics, as well as policies developed by employers and guidance produced by professional bodies.

Structure of the standards of proficiency ("the standards")

2.5   Each set of standards is unique to each of our 15 registered professions while based around a common set. The standards themselves are made up of 15 overarching standards, which are then broken up into generic standards (which apply to all professions) and standards specific to each profession (profession-specific standards). The purpose of the generic standards is to recognise commonality across all the professions that we regulate. The profession-specific standards set out the threshold requirements which are relevant to the specific profession.

2.6   The standards of proficiency are not hierarchical in order and are all equally important. We have aimed to order the standards in a way that seems logical and clear. This means that we have listed the generic standards first, followed by profession-specific standards.

Language used in the standards

2.7   The standards of proficiency must represent the minimum standards for safe and effective practice. This means that they have to be relevant and applicable to prospective registrants applying to come on to the Register for the first time and who are not yet in practice, as well as existing registrants throughout their practice and career.

2.8   The language used in the standards plays an important role. We intentionally use verbs such as 'understand', 'know', and 'be able to', to ensure that both prospective registrants and current registrants will be able to meet the standards. For example: *be able to practise within the legal and ethical boundaries of their profession.*

2.9   This wording does not mean that we consider some standards to be more important than others or that a registrant currently in practice would not be expected to meet the standard if it's relevant to their scope of practice. To take the example above, we would expect registrants already in practice to practise within the legal and ethical boundaries of their profession at all times, even though the wording says 'be able to…' If we changed the wording of the standard above, for example, to 'registrants must practise within the legal and ethical boundaries of their profession' it could no longer be met by prospective registrants who have not yet practised in their profession.

2.10   We also write the standards in a way that means they are relevant to all registrants in a profession, regardless of their area of practice. For example, we may use the term 'service user' or words like 'treatment' or 'intervention', even though these may not be the preferred term for a particular profession. We do this to ensure that the standards are as clear and consistent as possible to all who may read them. We propose including a glossary in the new versions of the standards of proficiency, to make these terms clearer.

2.11   The standards are also drafted in language which should enable them to stay relevant if there are changes in the law, technology or working practices. We have therefore avoided referring to specific pieces of legislation or particular approaches, to ensure that the standards remain relevant over time.

2.12   We have received some feedback to suggest that the language and terminology used in the profession-specific standards for some professions needs to be amended to better reflect the practice of those professions. We hope that the new draft standards will address these concerns.

How we use the standards of proficiency

Approval of education programmes

2.13   The primary role of the standards of proficiency is to set out the skills, knowledge, and abilities necessary to become registered for the first time.

2.14   To enter on to our Register, students must complete an approved education programme. We conduct approval visits to education providers to ensure that the programmes meet the standards. Our standards of education and training cover areas such as admissions, assessment, and practice placements, and we approve programmes using these standards. A programme which meets the standards of education and training will also allow a student who successfully completes that programme to meet the standards of proficiency.

Registration and renewal

2.15   The standards of proficiency play a central role in how a professional becomes and remains registered with us.

2.16   Most applicants complete their study within the UK and apply for registration through our UK approved programme route. We assess all approved programmes to ensure that students who successfully complete them meet the standards of proficiency and are therefore eligible for registration.

2.17   International applications are also assessed against the standards of proficiency. Each application is assessed by assessors from the relevant profession to determine whether the applicant's education, training, and experience mean that they meet the standards.

2.18   Every time a registrant renews their registration, we ask them to sign a declaration to confirm that they continue to meet the standards of proficiency which apply to them and their scope of practice.

Fitness to practise

2.19   If a registrant's fitness to practise is called into question, we will consider whether the registrant has the skills, knowledge, experience, character, and health to practise their profession safely and effectively.

2.20   To do this we may look at the standards of proficiency in deciding whether we need to take any action. This does not mean that we will take action if a registrant does not meet all of the standards for their profession, but we may

use the standards to decide whether they are practising safely and effectively within their individual scope of practice.

2.21   If a registrant's scope of practice extends beyond the standards of proficiency, we would expect them to continue to practise safely and effectively within their scope of practice, even if their scope of practice is not covered specifically by the standards. The standards of proficiency therefore do not represent the upper limit of the skills, knowledge, and experience a registrant may need to demonstrate to work safely and effectively within their scope of practice.

Scope of practice

2.22   When registrants renew their registration, they must sign a declaration to state that they meet the standards which apply to them.

2.23   Once someone becomes registered, we recognise that their scope of practice may change. We define scope of practice as the area or areas of a registrant's profession in which they have the knowledge, skills, and experience to practise lawfully, safely, and effectively, in a way that meets our standards and does not pose any danger to the public or to themselves.

2.24   A registrant's scope of practice may change over time, and we recognise that the practice of experienced registrants often becomes more focussed and specialised than that of newly registered colleagues. This might be because of specialisation in a particular area of practice or with a particular group, or a movement into roles in management, education, or research.

2.25   A registrant's particular scope of practice may mean that they are unable to continue to demonstrate that they meet all of the standards of proficiency that apply for the whole of their profession. As long as they make sure that they are practising safely and effectively within their given scope of practice and do not practise in the areas where they are not proficient to do so, they should continue to meet HCPC's regulatory requirements.

3. Analysing your responses

3.1   We have analysed all the written and survey responses we received in response to the consultation. We have also included feedback that we received from participants during Service User Engagement Workshops which were facilitated by an external research partner and conducted in the last quarter of 2020.

Method of recording and analysis

3.2   The majority of respondents used our online survey tool to respond to the consultation. They self-selected whether their response was an individual or an organisation response, and, where answered, selected their response to each question (e.g., "yes", "no", "partly", or "don't know").

3.3   Where we received responses by email or by letter, we recorded each response in a similar format.

3.4   When deciding what information to include in this document, we assessed the frequency of the comments made and identified themes. This document summarises the common themes across all responses and indicates the frequency of arguments and comments made by respondents.
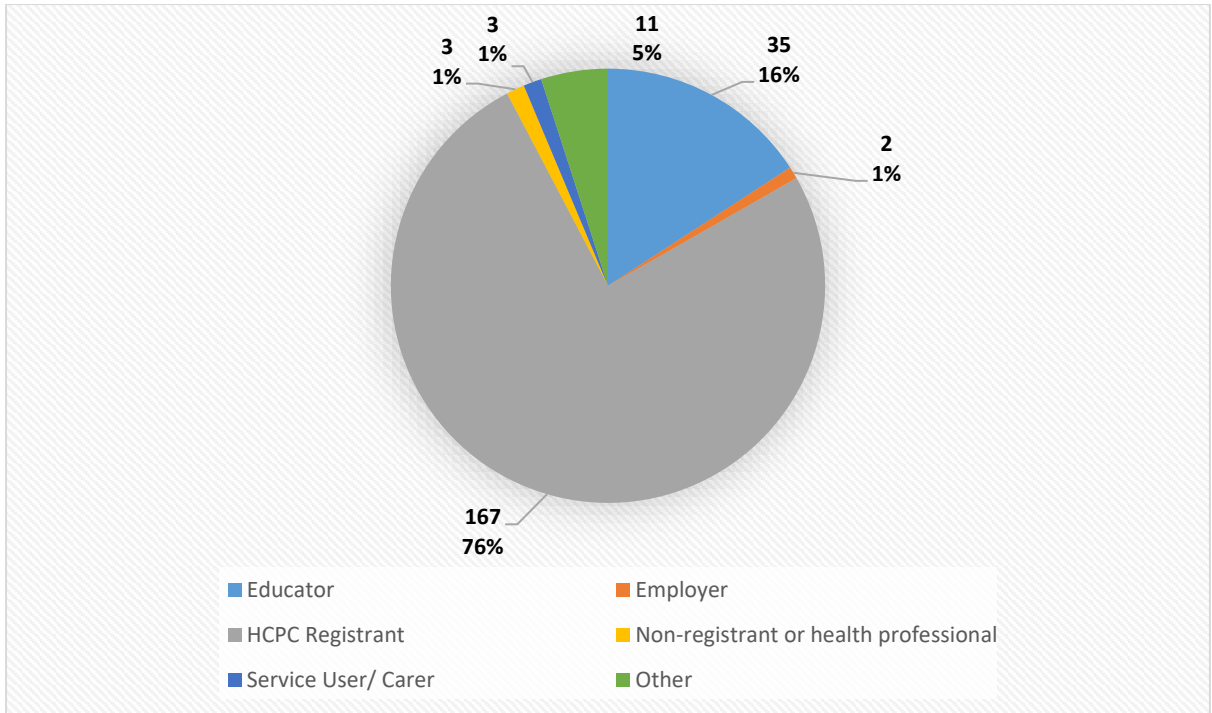
Quantitative analysis

3.5   We received 297 responses to the consultation. 221 responses (73.91%) were made by individuals and 78 (26.09%) were made on behalf of organisations. Of the 221 individual responses, 167 (75.23%) were HCPC registered professionals.

Graph 1 – Breakdown of individual respondents

3.6   Respondents were asked to select the category that best described them. The respondents who selected "other" identified themselves as students; a lay member of a regulating council, "Response on behalf of the All Wales Directors of Therapies and Health Science"; an HCPC Registrant/Educator; a non-registered Speech & Language Therapist, an Occupational Therapist; a team lead and a prospective registrant

Pie chart legend:
- Educator
- Employer
- HCPC Registrant
- Non-registrant or health professional
- Service User/ Carer
- Other

Data labels: 11 5%, 35 16%, 2 1%, 167 76%, 3 1%, 3 1%
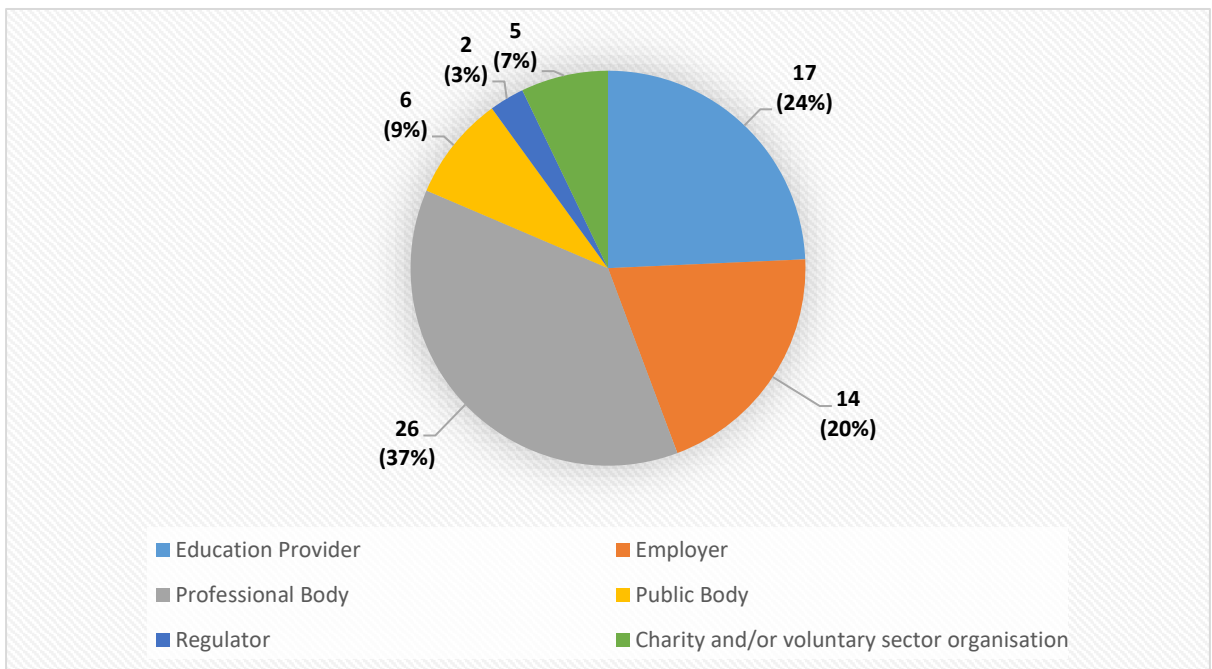
Graph 2 – Breakdown of organisation respondents

3.7   Respondents were asked to select the category that best described them. The respondents who selected "other" identified themselves as Trades Union; a strategic Health Authority; a PSA voluntary accredited registration body; a Professional network and a Professional Body/Trade Union.

Pie chart legend:
- Education Provider
- Employer
- Professional Body
- Public Body
- Regulator
- Charity and/or voluntary sector organisation

Data labels: 17 (24%), 14 (20%), 26 (37%), 6 (9%), 2 (3%), 5 (7%)

3.8 Our consultation questions allowed for a mixture of quantitative and qualitative responses to be provided. The tables below provide some indicative statistics for the answers to the consultation queries. Where answers are only of a qualitative nature, the question on the table has been greyed out.

Table 1 – Breakdown of responses by question

	Yes	No	Don't know	Didn't Answer
Q1: Do you think the generic standards make it clear that registrants must ensure their practice is equal, fair, and inclusive in their approach to all service users?	233 (78%)	22 (7%)	42 (14%)	0 (0%)
Q2: Do you think the generic standards place enough emphasis on the importance of the service user in decision making?	211 (71%)	32 (11%)	54 (18%)	0 (0%)
Q3: Do you think the generic standards are clear enough about the importance of maintaining fitness to practise?	225 (76%)	28 (9%)	44 (15%)	0 (0%)
Q4: Do you think the generic standards adequately address the importance of keeping up to date with technology and digital skills?	199 (67%)	56 (19%)	42 (14%)	0 (0%)
Q5: Do you think the generic standards are clear about the role leadership plays for all registrants?	186 (63%)	51 (17%)	60 (20%)	0 (0%)
Q6: Do you have any comments about the profession-specific standards?				
Q7: Do you have any comments on the proposed amendments to the preamble and glossary to the standards of proficiency?				
Q8: Do you consider there are any aspects of our proposals that could result in equality and diversity implications for groups or individuals based on one or more of the following protected characteristics, as defined by the Equality Act 2010?	38 (13%)	173 (58%)	57 (19%)	29 (10%)

Q9: Do you consider that our proposals are proportionate to our role to protect the public, and represent the threshold level necessary for safe and effective practice?	215 (72%)	14 (5%)	43 (14%)	25 (8%)
Q10: Do you have any additional comments about the standards of proficiency?				

Table 2 – Breakdown of responses by respondent type

	Individuals				Organisations			
	Yes	No	Don't Know	Didn't Answer	Yes	No	Don't Know	Didn't Answer
Q1	181 (87%)	15 (7%)	12 (6%)	0 (0%)	43 (56%)	6 (8%)	28 (36%)	0 (0%)
Q2	157 (75%)	29 (14%)	22 (11%)	0 (0%)	43 (56%)	3 (4%)	31 (40%)	0 (0%)
Q3	171 (82%)	21 (10%)	16 (8%)	0 (0%)	46 (60%)	4 (5%)	27 (35%)	0 (0%)
Q4	153 (74%)	36 (17%)	19 (9%)	0 (0%)	38 (49%)	18 (23%)	21 (27%)	0 (0%)
Q5	141 (68%)	37 (18%)	30 (14%)	0 (0%)	37 (49%)	12 (16%)	28 (36%)	0 (0%)
Q6								
Q7								
Q8	26 (13%)	136 (65%)	33 (16%)	13 (6%)	14 (18%)	32 (42%)	21 (27%)	10 (13%)
Q9	167 (80%)	10 (5%)	17 (8%)	14 (7%)	42 (55%)	5 (6%)	24 (31%)	6 (8%)
Q10								

- Percentages in the tables above have been rounded to the nearest whole number and therefore may not add up to 100 per cent.

Summary of responses on the generic standards

Equality, Diversity, and Inclusion (EDI)

3.9   The majority of respondents (78%) agreed that the generic standards make it clear that registrants must ensure that their practice is equal, fair and inclusive in their approach to all service users. A further 14% chose "don't know" and 7% disagreed.

3.10   Despite broad support for our proposals, respondents stated that we could go further in this area. They thought that our language was too passive in tone and could be made more robust by requiring registrants to be actively anti-discriminatory rather than non-discriminatory. Respondents also suggested we include content on topics like unconscious bias, privilege, reasonable adjustments, cultural change, and barriers to inclusion.

3.11   Proposals relating to wider standards were also suggested, such as making our standards on safeguarding more active, reviewing language (for example to ensure consistent use of the term "service users" throughout), improving content on capacity to make decisions and addressing digital literacy.

3.12   The feedback from the Service User Engagement Workshop echoed consultation responses.[1] Service users indicated that this was an important topic but that our expectations were currently more vague than other areas.

Service user involvement

3.13   The majority of respondents (71%) agreed that the generic standards placed enough emphasis on the importance of the service user in decision making. A further 18% replied "don't know" and 11% disagreed.

3.14   Those that were didn't know or disagreed suggested that that the standards could be strengthened, and further detail provided. Service user's capacity and consent were frequently raised, in addition to suggestions that the language we used be strengthened. Changes were proposed to make our standards more service-user-centred.

3.15   Participants of the Service User Engagement Workshop welcomed the increased emphasis on this topic, but suggested we include more detail on how registrants are expected to remove barriers to engagement and the

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[1] An external research partner facilitated engagement workshops with service users over a period of three weeks in November 2020. 24 participants took part in the research, 14 of whom had seen at least one of the professionals registered with the HCPC in the previous 12 months. The workshops explored the views of service users on the revisions proposed to the generic standards at our consultation. These views were complied into a report are referred to throughout this analysis document.

importance of listening. Participants also expressed concerns about the use of language like "personal incompatibility".

Maintaining fitness to practise

3.16   The majority of respondents (76%) agreed that the generic standards are clear enough about the importance of maintaining fitness to practise. A further 15% did not know and 9% disagreed.

3.17   Respondents who did not know or disagreed expressed concern about language like "coping strategies" and the inclusion of mental health in the standards generally. Respondents noted that including reference to "coping strategies" might have negative unintended consequences, whereby registrants could be forced to endure situations which are detrimental to their fitness to practise, or potentially limit the availability of help for registrants, due to an expectation they will be able to "cope". There were also comments that the inclusion of reference to mental health would mean registrants feel they could not practise with a mental health problem, and that this could lead to registrants being reluctant to seek help or to report an issue.

3.18   Several responses requested that we provide definitions for mental health or fitness to practise so a registrant is better able to assess if they are meeting this standard.

3.19   Respondents suggested we more clearly show the link between maintaining fitness to practise, continuous professional development (CPD) and supervision. It was suggested that drawing this link could make it easier for registrants to understand the steps they need to take. It was also requested we link this to EDI.

3.20   Participants at the Service User Engagement workshop were very positive about the addition of mental health. They indicated that this was important to help destigmatise mental health and the needs of health and care professionals. They also recognised this could in turn have positive impact on service users.

Technology and digital skills

3.21   The majority of respondents (67%) agreed that the generic standards adequately addressed the importance of keeping up to date with technology and digital skills. A further 19% disagreed and 14% didn't know.

3.22   Regardless to whether respondents agreed or disagreed with this question, a general theme which emerged from responses was that the proposed standards relating to technology and digital skills needed to be more robust. It was suggested that we highlight technology and digital skills across other areas, including confidentiality, record keeping, communication. Other

respondents noted that requirements relating to digital skills could be exclusionary to certain groups and suggested the standards expressly note this challenge. Where responses were supportive, they noted that "digital" does not appear in the generic standards and our language needed to change to make it clearer registrants needed to be able to apply these technology and digital skills within their scope of practice. It was also highlighted that a registrant's ability to meet these standards could rely upon their employer and their employer's investment in new technology.

3.23   In general, participants in the Service User Engagement Workshop were supportive and recognised digital skills were important, particularly during COVID-19. They however cautioned placing too much emphasis on these skills, noting it could have a negative impact on service user / registrant relationships, and that digital skills should be viewed as a tool to accomplish the overall goal of health and care professionals and not as an end in itself.

Leadership

3.24   The majority of respondents (63%) agreed that the standards were clear about the role leadership plays for all registrants. A further 20% chose "don't know" and 17% disagreed.

3.25   Although many respondents were supportive of the proposals, some suggested that we could go further. It was highlighted that leadership was only mentioned once within the standards and that we needed to make it clear that leadership is important at all levels of registrants' careers, that leadership styles need to be adaptable and that there was a link into EDI and tackling inequalities.

3.26   However, other respondents questioned how leadership would apply for registrants in non-leadership roles. Some suggested we use another term to avoid confusion. Responses also called for additional content on topics such as, supervision, delegation, raising concerns, the differences between leadership and management, formal and informal leadership and the wider context e.g. leadership in service delivery.

3.27   Participants at the Service User Engagement Workshop had mixed views about this topic. Around half considered it was an important addition, but others questioned the link between being a competent registrant and demonstrating leadership.

Profession-specific standards

3.28   We received a wide range of feedback on the profession-specific standards, as well as feedback on the wider generic standards which did not feature in

responses to our consultation questions on the generic standards.

3.29   Key themes included our use of language, with many commenting on the standards being too passive and not specific enough for implementation. There were also responses about specific language we use in the generic standards, and its relevance to all professions. Changes to wording were proposed in some areas to improve the readability of the standards.

3.30   Changes were proposed to the profession-specific standards to better reflect the modern-day practice of certain professions. In some cases, we received responses about certain proposals and their impact on registrants not demonstrating these standards in their day-to-day practice – for example, whether biomedical scientists would be able to meet proposed standards relating to service user consent, given the profession's lack of contact with service users in many settings.

3.31   We also received requests for additional information on a wide range of topics, ranging from guidance about how the standards apply in practice, to specific detail on particular processes and legislative requirements in practice.

Preamble and Glossary

3.32   Only 22% of respondents provided comments on the preamble or glossary, with the majority (61%) providing no comments. Where comments were made these mainly related to either language used or to the terms and definitions in the glossary.

3.33   As in previous questions, respondents questioned the use of passive language like "be able to". We also received some questions about how the standards relate to scope of practice.

3.34   We were asked to define more terms, like "modality", "stakeholder" and "supervision". We were also asked to revise the definition of several terms, such as "inclusive", "consent" and "leadership".

Equality and Diversity Impacts

3.35   The majority of respondents (58%) did not consider that our proposals would result in negative equality and diversity implications for groups or individuals based on one or more of the protected characteristics defined by the Equality Act 2010 and equivalent Northern Ireland legislation.

3.36   13% of respondents considered there were aspects of our proposals that may have negative equality and diversity implications. This included on the

grounds of disability and age, in relation to digital literacy and English Language requirements in particular.

Proportionality

3.37   The majority of respondents (72%) agreed that our proposals were proportionate to our role to protect the public and represented the threshold level necessary for safe and effective practice. A further 14% chose "don't know" and 5% disagreed.

3.38   Responses to this question covered a wide range of topics and reiterated comments raised in earlier questions, including the language and wording of the standards. Some respondents commented that the standards fell short of a certain profession's threshold or were not flexible enough for modern day practice. We were also asked to include more information or additional standards on registrant health and wellbeing, drug administration, informed consent, supervision, delegation and complaints.

Other comments

3.39   Nearly half of respondents took the opportunity to add further comments to their responses using free text boxes provided for this purpose. These discussed a range of topics, including our writing style, language and presentation, supervision and delegation, CPD and mentoring of students, EDI and our current English Language requirements.

4. Thematic analysis of responses

4.1   This section provides an analysis of the responses we received, based on the common themes we identified.

4.2   As this section analyses responses, we have received to our consultation, it makes reference to numbering which was used in the consultation document. Therefore, references to standards in this section, including their numbering, refer to the standards as they were presented for consultation. A table of these standards can be found [here](#)[2].

Question 1: Do you think the generic standards make it clear that registrants must ensure their practice is equal, fair, and inclusive in their approach to all service users?

4.3   The vast majority of respondents (78%) agreed with this question, welcoming the enhanced clarity and focus on inclusive practice. Only 7% said "no" and the rest chose "don't know" but didn't elaborate.

4.4   Respondents felt it was helpful to see a greater focus on inclusivity and socio-cultural perspectives in the standards and reported that the revised wording was clearer and more transparent, and more accessible to service users. Respondents highlighted that cultural competency must be at the heart of these new standards.

Language: The duty to act beyond awareness

4.5   Although they welcomed the enhanced focus on this area, some respondents felt the language was too passive in tone, that in places it was ambiguous and that it could be strengthened. They outlined that registrants' have a duty beyond "awareness and understanding", to seek to address barriers to inclusion that directly and indirectly result in discrimination, and thereby cause inequalities. Respondents stated that the language did not go far enough to indicate that professionals are required to *act* in a direct way in accordance with what is expected of them professionally.

4.6   One example given by respondents of how the wording should be altered is in standard 6 from "*be able to* practise in a non-discriminatory and inclusive manner" to "*practise* in a non-discriminatory and inclusive manner".

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[2] The standards which were originally presented for consultation can be accessed here: https://www.hcpc-uk.org/globalassets/meetings-attachments3/council-meeting/2020/02.-25.03.2020/enc-10---review-of-the-standards-of-proficiency-consultation.pdf

4.7   One respondent felt the proposed wording didn't make it clear that it is every professional's individual responsibility to be aware of safeguarding procedures and reporting processes and to understand their role.

Language: Explicit reference to biases and privileges and their impact

4.8   Eleven respondents felt the concept of bias; awareness/identification of personal and/or unconscious biases and how it affects practice and working relationships; and how to address bias, had not been explicitly referenced, and should be.

Language: Inclusivity

4.9   Four responses indicated that some of the language would benefit from being revised to better model inclusivity, and that the definition and scope of who is a service user, required further consideration. They said they would welcome more inclusive language relating to "service users", which they stated may exclude some registrants such as those working as service managers, university lecturers or in Arm's Length Bodies, in its current form

4.10   Similarly, other respondents indicated further consideration needed to be given to the definition of service user to take account of different settings and scenarios.

4.11   Another respondent suggested the inclusion of a broader view of equal, fair, and inclusive practice to consider interactions with other staff and colleagues, in addition to service users. Another suggested that the title of Standard 6 needed "and inclusive" to be added in.

4.12   Two respondents felt that at standard 2.5, the phrase "*personal incompatibility*" was not appropriate and suggested changing it to: *"recognise that relationships with service users should be based on mutual respect and trust and be able to maintain high standards of care in all circumstances."*

Reasonable adjustments and inclusion health

4.13   Four respondents suggested the standards should require registrants to understand their legal responsibilities to make reasonable adjustments and ensure inclusive practice.

4.14   One respondent felt the wording of Standard 8.4 should more clearly take account of the Accessible Information Standard[3].

Health inequalities, social determinants of health

4.15   A few respondents highlighted the need to elaborate on the impact of the sociological factors that affect health.

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[3] https://www.england.nhs.uk/ourwork/accessibleinfo/

4.16 Three respondents felt that the standards didn't set a high enough standard or make explicit reference to barriers to inclusion/inclusion health and addressing health inequalities.

Additional detail/specificity

4.17 A few respondents felt that greater detail was required in the proposed standards, such as:

- An addition that reflects the importance of the Welsh language for education and services in Wales.
- An instruction at standard 2.6 (informed consent) to consider everyone's capacity to give consent in each specific circumstance.
- An addition of further points at standard 5 *"to promote equality, social justice and inclusion in their work"*; *"to actively contribute in culture change across organisation to ensure inclusion is key to all activities"*; and, *"to actively seek to include other voices to ensure we practise in a way that is non-discriminatory including service users and colleagues (including students)."*
- An addition that references dementia or co-morbidities and awareness or understanding of these and other long-term conditions.
- Making arrangements to communicate effectively with someone who:
  - has impaired hearing, speech or sight
  - lacks mental capacity or has a learning disability.

4.18 Respondents also requested new standards on:

- Listening to patients, carers, and guardians, and accepting that they have insight into, preferences for and expertise about the patient's own condition and context.
- Making appropriate arrangements where patients request to see a professional of the same gender as themselves.
- The Equality Act 2010 and requiring registrants to know the principles of equality legislation in the context of patient care.

Digital Literacy

4.19 Three respondents felt that that digital literacy should be covered to ensure that everyone is given the same fair and equal access and receives the same high quality and appropriate healthcare.

Gender reassignment

4.20 Three responses highlighted that the SOPs at 5.3 should include "gender reassignment" to be as quoted in the Equality Act 2010 where it states the protected characteristic is "gender reassignment" and not "gender" as was set out in the consultation document.

Culture and socioeconomic status

4.21   Respondents highlighted that culture and socioeconomic status are not protected characteristics, although are nevertheless crucial considerations in effective communication with patients. They suggested perhaps the list could make clear the nine protected characteristics, while separately highlighting the importance of other factors such as culture and socioeconomic status.

Profession specific feedback

4.22   There were three responses that indicated that the language in the standards needs to be cognisant of the settings of all 15 professions, not just those in medical settings.

4.23   One respondent stated that they preferred the original wording to those of the proposed standards 2.3 and 2.4. They felt that in both cases the changes seem to envisage that all Registrants work in medical settings and highlighted that it is important that the HCPC recognise that some Registrants, for example educational psychologists, work largely within educational settings.

Service User Engagement Workshops

4.24   In workshops held with service users, carers and members of the public, participants spontaneously raised the importance of equality, diversity, and inclusion and of putting service users at the heart of decision-making when asked how they expected to be treated by a registrant. They went on to broadly welcome the standards set out by the HCPC in these areas. They felt that the standards were a step in the right direction in ensuring inclusive practise and empowering all service users.

4.25   Despite this, standards around equality, diversity and inclusion were generally considered more "vague" than those designed to put service users at the heart of decision-making and there were mixed levels of confidence in relation to how equality, diversity and inclusion would be translated into registrants' practice. In part, this was suggested to be driven by the passive nature of "be aware" and recognition that registrants may struggle to identify their own underlying beliefs (unconscious bias).

Question 2: Do you think the generic standards place enough emphasis on the importance of the service user in decision making?

4.26   The majority of respondents to this question (71%) agreed that the generic standards place enough emphasis on the importance of the service user in decision making, while 18% chose "don't know", and 11% disagreed.

Yes

4.27   A large majority of individual responses (75%) agreed with the question, compared to a lower proportion (56%) of organisations. The majority of those

that agreed did not provide further comment. Those that did praised the revised statements for their increased clarity and greater emphasis, noting that:

- The language was more inclusive and highlighted the importance of service users in the patient-clinician relationship;
- They clearly set out the importance of informed consent and shared decision making, and made it clear that service users must be at the heart of the decision-making process;
- They highlighted the importance of supporting and empowering service users throughout; and
- Practical application of the word "service user" in place of "patient" was welcomed.

4.28   However, a small number of respondents that agreed with the question also caveated their response in some way:

Use of language and terminology

4.29   Several respondents made suggestions about the language and terminology used in the standards. This included incorporating specific reference to children and young people, the need to consistently refer to service users and their carers, and the potential for even greater emphasis on service user involvement.

The importance of informed consent and capacity

4.30   Two respondents highlighted the importance of obtaining valid consent to support decisions made in the best interests of the service user, especially where there are capacity issues.

Involving service users in practice and the wider context

4.31   Though in agreement, a small number of respondents used this question to highlight the challenges of involving service users in the decision-making process. They cited a lack of face-to-face contact in some settings (prevalent in roles such as biomedical scientists) and increasing service user expectations (over and above the resources available) as examples.

Don't know

4.32   A minority of respondents (18%) did not know whether the proposed revisions placed enough emphasis on the importance of the service user in the decision-making process. However, analysis by stakeholder group revealed that a sizeable portion of organisations (40%) did not know, compared to just 11% of individual respondents.

The level of detail

4.33   Respondents indicated that whilst the need for service user engagement was clear, the emphasis on the importance of their involvement could be strengthened. Suggestions included:
- a greater focus on the principle of informed consent;
- highlighting the need to consider service users' cultural, religious and linguistic needs, and actively seeking their feedback;
- including detail about the legal requirements of involving patients in decision making;
- Including relatives as a group to communicate effectively with; and
- Explicitly referencing shared decision making with children and young people.

Use of language

4.34   Several respondents felt that the language used could be amended to strengthen the importance of service user engagement. Several respondents felt the importance of patient-centred/personalised care and decision-making should be explicitly referenced.

4.35   Some respondents felt the language should be amended to place greater emphasis on patients and co-ownership of their health and to give clarity about what is expected.

Right to refuse treatment

4.36   The right to refuse treatment was discussed by two respondents, who felt that this should be explicitly referenced in our standards. One respondent was concerned that the language used could imply that a health professional should facilitate a decision to be made, even if the service user did not want treatment.

Consent

4.37   The importance of understanding and being able to obtain informed consent was discussed by a few respondents, who felt that our standards could be strengthened in this area.

Application across HCPC professions

4.38   A few respondents cautioned that the focus on service user involvement was not appropriate for or applicable to all professions. The difficulty of biomedical scientists applying this standard was mentioned by three respondents.

4.39   One respondent in particular noted that the proposed requirement for registrants to "be able to work with service users" may be difficult for certain professions to meet and suggested that the reference in the legacy standards

to "understanding" the importance of service user engagement was more appropriate.

Advocating on behalf of patients

4.40   One respondent suggested that greater focus be placed on the importance of advocating on behalf of patients and service users, particularly those lacking capacity such as young children and vulnerable adults.

No

4.41   A minority of respondents (11%) felt that the proposed standards did not include sufficient emphasis on the importance of service user engagement. Of the individuals that responded, a somewhat higher proportion (14%) disagreed compared to organisations (4%).

Level of detail

4.42   Many respondents that disagreed stated that the proposed standards did not go far enough, and that the emphasis on service user involvement needed to be strengthened and made more explicit. This was particularly raised in relation to informed consent and conflict of interests.

4.43   One respondent noted that while certain sections of the standards clearly articulated the importance of engagement (section 8 and 9), this wasn't reflected throughout (for example in sections 4 and 14).

Capacity of the service user

4.44   One respondent stated that the proposed standards were limited by not explicitly referencing capacity, on the basis that capacity is an essential component to ensuring that service users have a voice and the right to make decisions about their care.

Service User Engagement Workshop Feedback

4.45   When introduced to the proposed standards, participants welcomed the increased emphasis on service user involvement. It was felt that the proposals helped to reaffirm the importance of acting in the best interest of the service user and would serve to empower individuals to take more control over their care.

4.46   However, participants questioned whether the proposed standards could be difficult to achieve in certain situations. They suggested including more detail about: how registrants are expected to remove barriers to engagement; how to respond when informed consent is not possible; and explicit reference to the importance of listening to the service user. Another questioned whether

"having the information they need" should include being told that the professional is registered.

4.47   In addition, participants were concerned about reference to "personal incompatibility" (Standard 2.5), and felt that should this situation arise, they would expect a service user to be referred to another professional. Others believed that referencing personal incompatibility led them to question their wider understanding about what it means to be a healthcare professional.

4.48   One participant also questioned whether the traditionally paternalistic attitude that exists in healthcare could act as a barrier to services users taking a lead role in the decision-making. It was felt that a culture change might be needed to empower service users to take control. It was suggested that an additional standard could be included specifying the importance of professionals promoting shared decision-making and advocating on behalf of their patients.

Question 3: Do you think the generic standards are clear enough about the importance of maintaining fitness to practise?

4.49   A large majority of the respondents agreed that the generic standards were clear enough about the importance of maintaining fitness to practice with 76% answering "yes", 15% "don't know" and 9% "no".

4.50   When separated by types of respondents, an even larger majority of individual respondents (82%) agreed. Where the survey was answered on behalf of an organisation, 60% agreed.

Yes

Inclusion of mental health

4.51   Respondents generally welcomed the proposed inclusion of mental health in the standards as well as the proposed standard setting out that registrants are personally responsible for maintaining their health. Respondents felt the inclusion of mental health alongside physical health in Standard 3.2 was a positive development which highlighted the importance of registrants' wellness and mental health.

4.52   Two respondents suggested that the standards should also include a responsibility to recognise when a colleague is struggling with their health and to take action where necessary.

Role of employers

4.53 Several respondents raised concerns that the role employers play in enabling a registrant to meet their standards was not fully acknowledged and the proposed standards suggested that registrants have more control over the drivers of stress in their workplaces than they actually do.

4.54 Respondents noted that employer practices relating to workloads and workplace policies relating to bullying or raising concerns were generally outside of a registrant's control and could have a negative impact on their health. Where a dysfunctional environment exists, it can drive poor health while also making it more difficult for registrants to seek assistance. Respondents stressed that employer policies around taking leave, for example, can create an environment which drives overworking, burnout, and poor mental health.

4.55 These responses often overlapped with the concerns being raised by respondents over the use of the word "coping" in the standards. In both cases, it was highlighted that while registrants have a duty to maintain their health, they may not be in full control of their working environment.

Don't know

While the overall percentage of respondents who chose "don't know" for this question was 15%, more than one-third (35%) of organisational respondents chose "don't know."

Language: Coping strategies

4.56 Nine responses argued that the word "coping" in proposed Standard 3.3 could have unintended consequences. Coping could suggest that registrants have to endure situations which are detrimental to their fitness to practise. While the standards emphasise the personal responsibility of registrants to maintain their health, these respondents felt that the use of coping could be construed to limit the available help for registrants if they needed assistance.

Inclusion of mental health

4.57 One respondent stated that the wording of Standard 3 did not make clear what options were available to a registrant who acknowledges that they cannot currently meet the standard. They went on to note that the wording could create an assumption that reporting an issue with your mental or physical health may result in a sanction from the HCPC or not being allowed to work.

No

Only 9% of respondents disagreed, with 10% of individual respondents and 5% of organisations selecting "no".

Language: Coping strategies

4.58   Many responses that disagreed with this question reiterated views by other respondents about the language of "coping strategies" with some noting that coping as a term could include both positive and negative coping strategies in times of stress (including substance misuse, for example).

Inclusion of mental health

4.59   One respondent noted that the proposed wording around mental health could be made clearer with a definition which captures the wide scope of mental health and acknowledge how mental health is impacted by, but not dependent upon, mental illness.

EDI

4.60   Two respondents suggested that the standards should set out an active duty for registrants to gain new knowledge and to understand the specific needs of marginalised clients.

4.61   One respondent felt that the fitness to practise ("FTP") process and the reliance on too many generic standards made the experience especially difficult for registrants with dyslexia.

Service User Engagement Workshop Feedback

4.62   In workshops held with service users, carers and members of the public, participants unanimously agreed that it was important to reference both mental and physical health within the standards; with most ranking it above digital skills and leadership.

4.63   Participants welcomed the inclusion of mental health and viewed this as part of wider work in society to destigmatise discussions about mental health. Linked to this, they thought it was important that the needs of health and care professionals "as people" were being considered.

4.64   As well as the obvious benefit to registrants, participants noted the benefit to service users of this proposed standard. Several participants argued that for health and care professionals to be able to offer safe and effective care for service users, they must themselves be in good health. The levels of trust and responsibility given to health and care professionals meant that when their own health was poor, they could make decisions which negatively impact on service users.

Question 4: Do you think the generic standards adequately address the importance of keeping up to date with technology and digital skills?

4.65   The majority of respondents thought the generic standards adequately addressed the importance of keeping up to date with technology and digital skills, with 67% of respondents answering "yes". 19% of respondents did not think that the standards adequately addressed the topic and a further 14% indicated they chose "don't know".

Yes

4.66   67% of respondents agreed. While a strong majority of 74% of individuals agreed, less than half of organisational respondents (49%) agreed.

Importance of digital skills

4.67   As set out above, most respondents welcomed the way that technology and digital skills were included in the standards and felt that this was a clear signal of the importance of these skills going forward. Several comments also noted that the inclusion of technology and digital skills in the standards was especially relevant given the acceleration of telehealth and other technology solutions in responding to COVID-19.

Language: Digital

4.68   Several respondents suggested including the word "digital" alongside "technology" as well as adding words like "skills" or "literacy" to both words in order to capture the importance of understanding and being able to apply digital skills.

Role of employers

4.69   While welcoming the inclusion of technology and digital skills, several respondents noted that a registrant's ability to meet this proposed standard could be dependent on their employer and the investments being made in new technology.

Accessibility and inclusivity

4.70   Two respondents highlighted that the proposed standards relating to digital, and technology should take account of how these mediums can actually increase the gap in access to services. While not a protected characteristic on its own, lack of financial and other resources can overlap with protected characteristics. Two respondents suggested that lack of access to resources could also create equality of access issues for new technology and digital tools, especially where registrants work in settings that do not invest in relevant technology or do not provide sufficient training.

No

4.71   19% of respondents disagreed with the proposed approach. For individual respondents 17% responded "no", while 23% of organisational respondents selected "no".

A more robust approach to technology and digital skills

4.72   Of those who responded "no" to this question, several felt that the standards relating to technology needed to be more robust and highlight the importance of technology to meeting all of the standards. These respondents felt that the mention of technology was too brief and generic and did not clearly set out the expectations for registrants.

Scope of practice

4.73   Three organisational responses discussed the need for clearer reference to scope of practise for standards relating to technology and digital skills. They argued that one reading of the proposed standards (Standard 14.1 in particular) would require a registrant to be conversant with technology relevant to their field, but not necessarily relevant to their role.

4.74   Linked to this was a concern raised by several respondents about the lack of investment by employers in new technology. They argued that, without explicit reference to scope of practice, a registrant could fail to meet this standard because they lacked access to certain technology.

Don't know

4.75   14% of overall respondents stated that they didn't know in response to this question. While 27% of organisational respondents chose "don't know", only 9% of individuals chose this option.

A more robust approach to technology and digital skills

4.76   Several of the respondents noted that they chose "don't know" because they felt the proposed standard was not clear enough. These respondents argued that a simple reading of the standards could suggest that the digital skills only related to basic IT and communication tools.

Language: Digital

4.77   One organisational respondent noted that the term "digital" should be added to the standards alongside the term "technology" as digital skills were not expressly mentioned.

Topol review

4.78   Two organisations felt that the standards should be shaped by the recommendations of the Topol review (which outlined recommendations to ensure the NHS "is a world leader in using digital technologies to benefit

patients") and also by all of the learning taking place as health and care professionals use technology in new ways during the pandemic.

Service User Engagement Workshop Feedback

4.79   In workshops held with service users, carers and members of the public, participants applauded the inclusion of digital skills in the standards.

4.80   Participants felt that digital skills were important for a number of reasons, including the generation of efficiency gains in the provision of healthcare and the important role played by digital and technology solutions in the response to COVID-19. One participant however highlighted that some digital solutions could also be exclusionary.

4.81   Whilst they were largely supportive, participants cautioned against too much emphasis being placed on these skills as they felt this could have a negative impact on the personal relationship between service user and registrant. They felt digital skills should be viewed as a tool to accomplish the overall goal of health and care professionals and not as an end in itself.

Question 5: Do you think the generic standards are clear about the role leadership plays for all registrants?

4.82   Of the 297 responses received, the majority of respondents (63%) agreed that the revised standards are clear about the role leadership plays for all registrants, while 20% chose "don't know", and 17% disagreed.

Yes

4.83   The majority of individual respondents (68%) agreed compared to just 48% of organisation responses. The vast majority of those that agreed chose not to provide further comment, but those that did welcomed the revisions for providing greater clarity and reemphasising the importance of leadership in practice.

Greater emphasis and the need for more detail

4.84   Though in agreement, a recurring theme was the need for greater emphasis on the importance of leadership for registrants. Respondents noted that leadership was only explicitly referenced in the proposed standards once and felt that this was insufficient.

4.85   Respondents felt the standards should:
- include reference to the role and importance of leadership at all levels;
- require an understanding of the need to adapt leadership style as appropriate depending on the profession of the individual, and their needs;

- highlight the need for appropriate delegation;
- set out an expectation of non-discriminatory practice, and the importance of removing implicit bias both on an organisational and individual level.

Terminology used

4.86   A small number of respondents commented that the terminology used in the proposed standards was confusing. For example, one respondent highlighted that not all registrants would have leadership roles, and therefore questioned whether standard 9.4 included registrants' understanding their place/role in the organisation more generally. Another respondent had issue with the phrase "context of practice" and felt that it was unclear whether this would mean that registrants would be expected to show leadership in all areas and at all stages of their careers. Greater clarity was therefore requested.

Practical application and the wider context

4.87   Though in agreement, some respondents highlighted the potential difficulties of applying this proposed standard in practice. It was discussed that, due to existing hierarchies, the standards would require "a revised mindset" for many registrants, and potentially greater support to enable them to think of themselves in this way.

Don't know

4.88   Nearly a quarter (20%) of all respondents 'didn't know' whether the standards are sufficiently clear about the role leadership plays for our registrants. However, closer analysis reveals that the number of organisations who chose this option (36%) is significantly higher than individual respondents (14%).

Emphasis and the level of detail

4.89   The most common feedback from respondents was that they felt that the standards were lacking sufficient emphasis on the importance of leadership, and that greater detail was needed. One respondent felt that the standards lacked clarity about what was expected of registrants, for example, whether they would be expected to "understand", "apply" or "consider" leadership as part of their practice.

4.90   Respondents put forward a few suggestions about what further detail could be included, such as the distinction between formal and informal leadership, and the difference between leadership and management skills.

Terminology used

4.91   A few respondents felt that the word "leadership" could cause confusion, particularly for those early on in their career with no formal leadership responsibilities, or those practising outside of the NHS.

4.92   A couple of respondents felt that alternative wording, such as "role model" or "influence", would be better suited and easier for registrants to understand.

One respondent in particular noted that they did not necessarily agree with the description of leadership proposed in the glossary and suggested that this should be revised.

The structure of the standards

4.93   It was considered that the concept of leadership was overshadowed by merely being part of the proposed standard 9. A few respondents therefore suggested developing additional standards specifically focused on leadership, to ensure greater emphasis and clarity.

Raising concerns

4.94   The connection between good leadership and raising concerns was raised by a few respondents, who felt that the importance of appropriately raising concerns, and supporting others to do so, should be made more explicit.

Leadership and combatting inequalities

4.95   Though referring specifically to the psychologist profession, one respondent discussed the role leaders play in combatting inequalities, and eradicating biased practices, both by themselves and of their teams. They criticised the standards for making no mention of how leadership teams are responsible for addressing inequities and social injustices within services.

No

4.96   A minority of respondents (17%) did not agree that the proposed generic standards were clear about the role leadership plays for all registrants.

Greater emphasis and the structure of the standards

4.97   One respondent noted that, while the qualities of good leadership run throughout the standards, these need to be made more explicit to ensure clarity and understanding.

4.98   However, similar to both those that agreed and those that chose "don't know", the majority of respondents that disagreed criticised the proposed standards for having insufficient reference to leadership and for its importance not being clear enough.

4.99   Several respondents suggested that an additional standard or subsection specifically focused on leadership would be beneficial, as this would help ensure clarity as well as bring its importance to the fore. It was also discussed that this would provide the opportunity elaborate further on other related issues, such as risks around abuse of power.

Level of detail

4.100 While the proposed standards made high level reference to "the qualities, behaviours and benefits" of leadership, several respondents felt that greater detail was necessary about what the qualities entail, what successful leadership looks like, and/or what the benefits are.

The context of leadership

4.101 A couple of respondents felt that the proposed standards lacked sufficient detail about the context of leadership, its broader application, and the various forms that it can take. For example, leadership in service delivery; change and innovation; education and training; and wider strategic goals of the NHS. It was therefore suggested that leadership needs to be more broadly defined and that the scope of standard 9 should be widened, in order to guide knowledge, awareness and practical application.

The role of leadership in addressing inequalities

4.102 Leadership was identified as having a core part to play in addressing and combatting bias and inequalities, both at a system and personal level. It was discussed that the responsibility of leaders to take ownership of addressing inequalities and ensuring social justice needs to be made explicit, to ensure positive and proactive steps are taken.

The wider context and application in practice

4.103 One respondent highlighted that, while leadership is extremely important, there are often limited opportunities for registrants to develop in this area, particularly in the current climate of austerity. They therefore cautioned that the HCPC should be mindful of barriers, and that whilst it is ultimately the responsibility of the registrant to ensure their development, this responsibility is also shared with a person's organisation and employer. Insufficient or limited guidance on leadership and the development of appropriate skills was also discussed.

Service User Engagement Workshop Feedback

4.104 Participants questioned the link between being a competent registrant and leadership, and some questioned whether it should be included in the general standards at all. Participants felt that not all registrants would be interested in demonstrating leadership, and also felt that opportunities to display this quality could be limited.

4.105 However, around half of participants felt that leadership was an important addition and drew important distinctions between formal leadership responsibilities and more general leadership qualities. It was however felt that further detail was needed to highlight its relevance to all registrants.

Question 6: Do you have any comments about the profession-specific standards? In particular we would welcome comments on the following:

   a.   **whether the standards are set at the threshold level necessary for safe and effective practice;**
   b.   **whether the wording of the standards is clear and appropriate; and**
   c.   **whether we should include any additional standards.**

4.106   A total of 297 respondents answered this question. Respondents were asked to select which profession's standards they wanted to provide feedback on. The analysis of this question is therefore split by profession.

4.107   Whilst this question is focused on the profession specific standards, many respondents also used this question to also provide more general feedback on the proposed standards, including the generic standards. This feedback is therefore also captured in the analysis below.

Arts therapists

4.108   We received 9 responses about the proposed arts therapists' standards. Six were from individuals (5 registrants and 1 student) and 3 were from organisations (2 professional bodies, BAAT and BAMT and an employer).

4.109   Two respondents expressed support of the standards, and three provided substantive comments, which are outlined below.

Safeguarding

4.110   One respondent felt that the standards should be clearer that registrants should have a competent knowledge of adult and child safeguarding procedures, including recognising signs of abuse (whichever age group they work with). This response recommended the standards should include knowing and recognising signs of abuse or other serious risks.

4.111   They also suggested that we include a standard on *"awareness of how capacity intersects with safeguarding when an adult is believed to be at risk"*.

Consent and capacity

4.112   One respondent suggested we include standards on seeking consent for treatment and how that intersects with capacity. For art therapy, they suggested we include standards on seeking consent to initiate and continue art therapy as well as consent to refer to other services, so this is made clear and explicit.

Language

4.113 A professional body suggested that the language used in the standards be updated and developed to more accurately represent contemporary socio-cultural perspectives on diagnosis, trauma-informed research, and the voice of the service-user in research that challenge a traditional understanding of diagnosis.

4.114 They also noted that some terms currently used *"imply an unequal power relationship between the registrant and the individual or group and rely on a Western diagnostic model"*. It was suggested that *"many service users prefer non-diagnostic, anti-labelling language in their communications and registrants could be supported in their practice if this is used in the SOPs"*.

4.115 A professional body made a number of suggestions about the wording of the standards. This included proposed revisions to the standards, deletion of standards where there was duplication and amendments to music therapist standards. They suggested we:
- change the wording of standard 4.8 to "understand the role and importance of ongoing supervision in supporting high standards of practice, and personal and professional conduct"
- revise standard 9.6 for clarity to make it clear this is about abiding by the limits of the role and recognising the potential contribution of other modalities
- amend 12.5 to "be able to evaluate care plans or intervention plans using recognised and appropriate outcome measures"
- amend 13.1 to "Appreciate and be actively informed by lived experiences of wellness and illness as well as the effects of social disablement and exclusion and be able to consider this alongside diagnostic knowledge relevant to their profession."
- revisions to 13.14 including removal of the language "normal and abnormal"
- amend 13.15 to "recognise different methods of understanding the experience of service users, including diagnosis (specifically mental health and learning disability) and be able to critique these systems of knowledge from differed socio-cultural perspectives"

Biomedical scientists

4.116 We received 16 responses about the biomedical scientist standards. 2 were from organisations (the professional body, IBMS, and an education provider) and 14 were from individuals (11 registrants, 2 educators and 1 non-registered health and care professional).

4.117 5 responses supported the standards but did not provide further comments or suggest amendments. A further 4 responses did not provide additional

comments. The remaining 7 respondents provided more detailed comments, the themes of which are summarised below.

Service user engagement

4.118 A key theme in the responses received was service user engagement and the limited ability of biomedical scientists to achieve this.

4.119 One response noted that proposed standard 2.6, on informed consent, was very specific and patient focused. They noted very few biomedical scientists are in the position to obtain informed consent.

4.120 Another stated that they had concerns relating to service user engagement and that these could only be met "at a distance" or in certain scenarios and not by direct contact with service users. They stated these needed to be updated in line with the real day to day role of a biomedical scientist in practice.

4.121 Finally, one response expressed concern with proposed standard 9.5 and the change from "patient care pathway" to "service user care pathway". They stated this has different connotations as in the context of this profession it could be taken to mean a company submitting environmental samples, for example. Similarly, they stated that on proposed standard 14.24 "service user" should not replace "patient", as the diagnostic test descriptor is called near patient testing or Point of Care Testing. They stated the terms "patient" and "service user" needed to be defined to ensure they are used in the correct context. They also noted that often Allied Health Professionals ("AHPs") do not use the word "patient" and instead refer to "customer" or "client", so the standards should reflect this.

Other comments

4.122 It was suggested we add in a new standard reading "be able to safely interpret and authorise patient results".

Chiropodist / podiatrists

4.123 We received 19 responses about the chiropodist / podiatrist standards. 3 were from organisations (all selected professional bodies, including the College of Podiatry and the Institute of Chiropodists and Podiatrists, but also included a private practice clinic and a podiatrist) and 16 were from individuals (14 registrants and 2 educators).

4.124 8 responses were in favour of the proposed amendments to the standards, noting they were clear, comprehensive, set at the correct level, easy to understand and suitably high level. One response however noted that they were "quite wordy". Another stated that we need to note these are the

minimum standards and that "advancement and development should be encouraged across all professions".

4.125 One response made several suggestions for changes to the standards. These included:

- Changes to reflect technology and digital skills adequately. The respondent noted the pace of change is fast in some areas and could result in division within the profession without due consideration of this in the standards. They also requested more detail on expectations for practice in embedding a fairer, more inclusive digital approach to provision.

- Reference to the need for registrants to support the future workforce through the facilitation of education and provision of practice placement experiences. They noted that, without this, the workforce will continue to decline both in number and in capacity.

Clinical scientists

4.126 We received 15 responses about the clinical scientist standards. 4 were from organisations (2 professional bodies, 1 trade union, the Federation of Clinical Scientists (FCS) and a PSA voluntary accredited registration body, the Registration Council of Clinical Physiologists). The remaining 11 were from individuals (9 registrants, 1 employer, 1 AHCS lay member of the Registration Council).

4.127 The majority of responses (10) expressed support for the standards, but suggested further standards were also required.

Additional standards

4.128 One respondent felt we should add in a section on how data should be stored and shared. Another said we should place greater emphasis on a registrant's responsibility for ensuring they maintain their knowledge as techniques and technology evolves.

4.129 Another response noted that many clinical scientists are crossing into patient clinics and becoming almost equivalent to Clinical Nurse Specialists. They therefore requested that the standards reflect the patient/scientist interaction including making decisions, managing patient pathways, and acting in the interest of the patient. Examples provided included ensuring it is clear clinical scientists should be able to manage clinics, be able to make reasoned decisions to initiate, continue, modify, or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately.

4.130 Similarly, another response argued that without recognition of the above, our proposals fell short of the HCPC's role to protect the public, as they did not

recognise the roles of clinical scientists who work less in laboratory settings and instead work directly with service users.

Dietitians

4.131 We received 11 responses about the dietitian standards. 9 were from individuals (7 registrants and 2 educators) and 2 were from organisations (the professional body, and an employer). Some responses did not provide further detail, other than to express support for the amends.

General comments

4.132 A professional body welcomed the preamble and in particular the greater clarity that as careers progress scope of practice also changes. They also welcomed the greater focus on the service user, leadership and the role of research/audit and use of technologies.

Language

4.133 We received comments about terminology, as follows.

- o On proposed standard 11.2, one response disagreed with the removal of "multi-disciplinary review" and felt that should be included along with case conferences and other methods of review.

- o A couple of responses questioned why psychology was removed from proposed standard 13.3.

- o The professional body expressed support for the term "service user", noting it "better reflects the range of settings that dietitians work in". They also suggested that standard 5.2 should include dietary as well as non-dietary factors.

Hearing aid dispensers

4.134 We received 6 responses about the hearing aid dispenser standards. These were from three individuals (2 registrants, 1 educator) and three organisations (2 professional bodies, BSHAA and the British Academy of Audiology, and 1 education provider).

4.135 Four of the five responses which provided comments expressed support for the revised standards, stating they were *"clear" "fitting for my profession"* and *"more logical in their presentation to link better with the service/procedure provided and the different aspects related to practice".*

4.136 The other response expressed support with *"the major thrust of some of the revisions"* but expressed concern that *"in striving to achieve greater clarity and more relevant language, some of the proposed changes will have unintended*

adverse consequences." The response highlighted the need for the standards to be clear and concise, stating they are *"intended for use by professionals who are expected to exercise professional judgement as they put these standards to use within their own practice context. When standards become overly detailed, they have the opposite effect of becoming too prescriptive (even when unintended) and discourage the registrant from owning the interpretation of that standard."* the respondent proposed numerous wording amendments, both to the generic and profession specific standards to alleviate these issues.

Paramedics

4.137 We received 17 responses in relation to the proposed paramedic standards. 3 were from organisations (the professional body, the College of Paramedics, a trade union and an education provider). The remaining 14 were from individuals (12 registrants and 2 educators).

4.138 A couple of respondents indicated they were supportive of the changes and did not have any more comments. However, the majority provided detailed comments on further changes that were required.

The threshold

4.139 A common theme in responses was that the proposed standards did not go far enough in reflecting current paramedic practice and therefore were not at the threshold. Responses in particular noted that the profession is developing at pace and that many paramedics are no longer working in traditional ambulance roles, but instead in specialist or advanced practice. Others made reference to the increase to degree level as the minimum qualification needed for application to the register (this change was implemented in September 2021, after the consultation on the standards of proficiency closed). One organisation highlighted that the generic and flexible language of the proposed standards meant that the threshold was much lower than what is currently expected of paramedics in practice.

4.140 A counter point was however raised by a couple of responses, stating the threshold was "too high for some IHCD paramedics"[4]. The response expressed concern that certain topics were not covered on IHCD courses and so paramedics trained to this level would need a top up degree for this to be threshold. Similarly, one response noted standards on "research, leadership, knowledge regarding pharmacokinetics nutrition, sociology and psychology" were not covered by the IHCD training, or their BSc top up.

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[4] IHCD refers to the Institute for Healthcare Development which validated the IHCD qualification for paramedics. The IHCD route was withdrawn and there are no open programmes currently accredited by the HCPC.

Additional standards

4.141 Wide ranging amendments were proposed to the text of both the generic and profession specific standards. These included content on:
- The self-referrals process
- The profession's role in public health and health promotion
- Appropriately challenging colleagues on unsafe or potentially dangerous behaviours and/or practice
- Social media use
- A stronger position on actively participating in mentoring / supporting students in education and training
- Emergency/time-critical specific expectations, including an emphasis of fitness standards required
- A greater focus on controlled drugs and medicines laws, including pain management, polypharmacy and adverse drug reactions
- Human Factors or Crew Resource Management
- Understanding, appreciating the limitations of, and being able to practice within recognised guidelines, and being able to justify deviations from these guidelines where required in the interests of an individual patient
- Reference to ethics
- Emphasis on paramedic's rights to perform remote risk assessments and request additional resources when exposed to dangerous situations
- Human development, growth, nutrition and genetics
- The effects of Behaviour and psychological factors on health and illness
- Health inequalities
- Major incidents, such as running a triage system

Patient vs service user

4.142 There were mixed views about the move from "patient" to "service user" in the standards.

4.143 Some responses felt this better reflected the wider range of roles paramedics now take on, including the professional body. An education provider welcomed the change, stating it "suitably reflects broader changes in terminology and the wider role we play in engaging with those beyond the patient group". However, others disagreed. One response argued that this change would negatively affect the relationship between paramedics and their patients. They argued that, whilst this might work for the generic standards, it wouldn't be appropriate for the paramedic specific standards.

Language amends

4.144 Several responses proposed re-writes or a re-structuring of the standards, or that standards be deleted where they were duplicated.

4.145 Language amends were generally suggested to reflect paramedic's wider roles (e.g., changing terms like "pre-hospital or out of hospital" to "paramedicine" or "paramedic practice"). One response highlighted language in the standards that they described as "a historical hang up" which fails to show paramedics as "autonomous, sentient practitioners". Suggestions were also made to make the language more active, such as removing "be able to" and instead requiring paramedics to demonstrate knowledge through action.

4.146 Other responses suggested that certain standards were not well suited to emergency care, in particular proposed standard 15.

4.147 One response however questioned the change of language from "know" to "understand" in standard 2.5. They argued this was onerous and excessive.

4.148 One response suggested the proposed standard on active participation in training, supervision and mentoring be amended to "within their capabilities". They argued not all registrants are able to do this and these are skills that cannot be taught.

4.149 One response noted the reference to care pathways in standard 14.10 was something paramedics would love to do, but often cannot access them or have difficulties accessing them. They also noted they are limited by ambulance service regulations about which care pathways they can use.

Occupational therapists

4.150 We received 28 responses about the occupational therapist profession specific standards. 24 were from individuals (19 registrants, 3 educators, 1 non-registered occupational therapist and 1 team lead). 4 were from organisations (1 employer, 1 education provider, 1 charity and the professional body, the Royal College of Occupational Therapists).

4.151 A small number of respondents indicated they were happy with the content. They noted that the proposed standards sufficiently covered the profession's *"primary role"* of occupation, were *"more occupationally focused",* were *"thorough and well put together"* and were *"inclusive and informative"*. We did, however, receive several responses that proposed further amendments. These are detailed below.

Language

4.152 We received detailed comments about the wording of the proposed standards, in relation to both the generic and profession-specific standards. We have analysed the general themes of these comments and listed them below.

4.153 Several responses highlighted inconsistencies in the language and phrases used in standards. These included:

- "Continuous professional development" vs "Continuing professional development".
- "Active participation" vs "active engagement".
- "Service users and carers" vs "service users, their families and carers" vs "service users, their relatives and carers".
- Use of the term "people" instead of "service user" or "individual".
- Duplication of "comprehensive" in proposed standard 10.1.
- Psychological vs mental health.
- Inconsistency in the areas of diversity in proposed standard 5 in the profession specific standards.
- Labelling of evidence and research to inform practice across the standards.

4.154 Some respondents questioned the use of passive language in the proposed standards, such as "understand" and "be able to". This was especially so for standards 6 and 14. One response acknowledged the complexity of framing standards in a way which enables new graduates to meet them, but said certain areas needed stronger language to set a more active expectation registrants can be held to. It was proposed we achieve this through language like "be able to understand and use" or "be aware of and draw upon". Another respondent suggested we use "understand and demonstrate".

4.155 A few respondents expressed concern about the length and wording of the standards. Responses suggested the proposed standards were too wordy and convoluted, making it hard to follow. This was said to be especially the case for standard 9, 13 and 14.

Additional content

4.156 Several respondents suggested additional standards, such as the inclusion of:

- Further detail on leadership, record keeping, duty of candour and Freedom to Speak Up.
- Greater reference to multi-disciplinary teams.
- Strengthened expectations around taking action when there is a safeguarding concern.

- More detail on consent and capacity and that consent needs to be recorded.
- More detail on legislation, including clear expectations that the individual understands how this influences their practice and where it limits this.
- A greater focus on advocacy and empowering service users, including consulting service users about issues wider than their own treatment.
- Greater emphasis on the importance of CPD and supervision, particularly in proposed standards 11 and 12 where one response felt this could be shown as a mechanism of reflection and quality control.
- Emphasis on safety when using digital technology or working remotely.
- A standard on the provision of occupational therapy practice education.
- Content covering resilience to cope in the work environment.
- Additional detail on service-user centred care, such as ensuring intervention reviews are informed by changes in service user's circumstances and ensuring registrants understand the relationship between the service user, their environment, and their chosen occupation.
- Reference to cultural contexts.
- Reference to maximising independence and function or quality of life.
- A more detailed approach to standards on research, covering both qualitative and quantitative, ensuring registrant's understand implications and including this learning in their practice.
- Reference to the occupational therapy process of assessment, planning and intervention.

4.157 We were also asked to avoid certain terms like "diagnostics" and instead use "assessment" to make it more appropriate for occupational therapy.

Operating Department Practitioners (ODPs)

4.158 We received 23 responses relating to the ODP standards. 4 were from organisations (3 education providers, 1 professional body, the College of ODPs) and 19 were from individuals (11 registrants, 5 educators, 3 student ODPs).

4.159 Three respondents expressed support for the changes, one respondent stated that the proposed standards were now "less vague and did not limit the role of the ODP". However, the most respondents provided detailed comments on further changes that were required.

Additional standards

4.160 A general theme in the responses across the proposed standards was that they needed to account of ODPs taking on roles outside theatres and the profession's expanding scope of practice. For example, one respondent asked that we refer to human factors in all settings, not just in perioperative and acute care.

4.161 One respondent noted the challenges of proposing additional standards, due to the variance in the ODP role across the UK. They argued however some standards could be enhanced, such as links to critical care and associated clinical areas (e.g., A&E and radiography) outside of the operating theatre.

4.162 Other suggestions included:
- Referring to auscultation in the standards.
- Clear guidance on working in ITU and end of life care.
- Making the role of the mentor for all professions more explicit.
- Adding a new standard on representing, upholding and promoting the profession.
- Introducing a standard about a duty to consider the environmental impact of practice, such as related to recycling (for all professions, not just ODPs).

4.163 A couple of respondents requested we strengthen certain standards, such as proposed standard 14.12 on the role of Surgical First Assistant in which respondents suggested the wording should change to substitute "be able" with the word "undertake" and proposed standard 13.14 which respondents said should include "participate as part of the team managing a clinical emergency".

4.164 However, one respondent expressed concern that registrants would not be able to meet some of the proposed standards. They referred in particular to standard 11A, 14A and 14D.

4.165 Similarly, a degree level education provider questioned how they would be able to meet proposed standards 14.11 and 14.18 (relating to all gender urinary catherization and common abnormal blood physiology). They noted that many would see this as an extended role that should be part of further qualification and that many mentors would not have this skill, so engagement with practice partners would be required and this would take "considerable work" so would require a long timeframe for implementation.

Language

4.166 Several respondents questioned what we meant by certain language. For example, we were asked what "service user monitoring equipment" meant in proposed standard 15.11. We were also questioned about the focus in proposed standard 14.18 on blood physiology, with the respondent expressing uncertainty about the standard's meaning. In relation to proposed standard 14.16, we were asked if registrants were expected to get further training before they were allowed to administer prescribed drugs. The respondent noted this is an issue for agency staff in particular, and further clarification would provide registrants with a clearer idea regarding what they can and cannot do without additional in-house training.

Other regulatory issues

Some respondents raised wider regulatory issues. These related to advanced practice, medical entitlements, and the education threshold, which we will deal with separately to this review.

Orthoptists

4.167 We received six responses about the orthoptist standards. Three were from individuals (2 registrants, 1 educator) and the remaining three from organisations (2 from the professional body, and 1 education provider).

Wording of the standards

4.168 A couple of comments noted that some of the proposed standards needed rewording and that there was repetition across the standards. Another respondent stated that the standards were *"very generic and would be applicable to other professions and do not distinguish from other ocular professions".*

4.169 One respondent suggested we change the use of "understand" in the standards to "describe", arguing this would aid in the implementation of standards for education providers and challenges for fitness to practise, as the registrant would have to articulate their knowledge.

The order of the standards

4.170 Several respondents made suggestions about the order of the standards within proposed standards 13 and 14 (profession specific and generic standards) to ensure standards of increased importance came first. It was also proposed that certain standards should be moved out of one section and into another. Suggestions were also made to reduce perceived duplication.

Standards 14.29 and 14.30

4.171 We received a few comments on amendments to standards 14.29 and 14.30. These amendments added in "be able to perform" to the current wording, which requires the profession to "understand the principles and techniques of" both anterior and posterior segments of the eye and objective and subjective refraction. A couple of responses expressed concern that this would mean registrants would be required to be proficient in these skills, noting that not all registrants would be able to perform these as they are only relevant to an extended role. One response stated, "*there is little value in being able to perform anterior and posterior segment assessments without a clear, detailed understanding of abnormal findings.*" This respondent also expressed concerns that *"this change potentially opens Orthoptists up to litigation for failure to detect ophthalmic conditions outside our scope of practice."*

4.172 However, we also received a response that countered this position from the professional body. This confirmed *"these skills are taught to a level of clinical competence at undergraduate level"* and that *"senior members of the profession believe they are core skills"* that are required at registration. They noted that historically these skills may not have been taught as well, meaning certain registrants feel less confident. However, they argued *"orthoptists need to recognise their limitations"* as with any other standard. This is because registrants must only meet the standards of proficiency relevant to their current scope of practice. The professional body also noted wide consultation with its members as part of their response, which demonstrated wide support for this change.

Other comments

4.173 One comment noted that additions should be made to *"reflect the inclusion of sales and administration of drugs"*. Another specifically suggested standard 13A be amended to specify which medicines orthoptists would be expected to use and to differentiate between standards for all orthoptists and those who are registered to supply and administer medicinal products on the orthoptist's exemptions list.

4.174 Another comment proposed changing standard 14.10 from "critically evaluate" to "critically appraise" to capture an orthoptists ability to ascertain the value of evidence, which is key for evidence-based practice based on high-quality evidence only.

Physiotherapists

4.175 We received 27 responses about the physiotherapist profession specific standards. 24 were from individuals (18 registrants, 2 educators, 2 service users, 1 non registrant health or care profession and 1 prospective registrant). 2 were from organisations (2 employers and the professional body, the Chartered Society of Physiotherapy).

4.176 9 respondents expressed support for the proposed standards, agreeing they were clear, appropriate, and met the threshold for safe and effective practice. One respondent noted the changes give a better framework for "holistic therapists".

Additional content

4.177 Several respondents made suggestions for additional content or language amendments. This included:

- Explicit reference to the use of interpreters / translators.

- A standard on digital / technology covering paper lite, team working, digital consultations, apps and safety aspects of technology.
- More emphasis on shared decision making.
- Detail on how long after contact registrants have to do clinical notes.
- Stronger references to being an advocate for service users in multi-disciplinary teams
- Reference to theories of health promotion and behavioural change.
- Reference to health informatics.
- Broadened language to include the private, charity and social care sectors.

4.178 One respondent felt the definitions in the glossary could be supported by further detail, and that leadership in particular should include skills of leading.

4.179 Another respondent noted the language is at times too generic, including in proposed standards 13.5 and 13.8. They argued that the standards need further detail about what would be suitable and current.

Other regulatory issues

4.180 A few responses used this question to provide feedback outside the focus of the consultation, these matters will be dealt with separately.

Practitioner psychologists

4.181 We received 32 responses about the practitioner psychologist profession specific standards. 23 were from individuals (19 registrants, 1 educator, 1 service user / carer, 1 student and 1 dual registrant / educator). 9 were from organisations (2 professional bodies, both the BPS, 2 charity and/or voluntary sector organisations, 1 employer, 1 education provider, 1 public body and 1 other – a professional body and trade union.

4.182 The vast majority of respondents suggested further amendments to the language used in the standards or proposed new standards. These are detailed below.

Equality, diversity and inclusion

4.183 Several respondents commented on our approach to EDI in proposed standards 5 and 6, arguing it did not go far enough. One respondent noted the need for more than just awareness, stating *"practitioners need to be able to use their psychological skills to challenge oppressive or discriminatory practice"*. They also suggested that *"casework must demonstrate anti-oppressive, anti-discriminatory, anti-racist, anti-transphobic and anti-homophobic practice"*. Another respondent argued for proposed standard 6 to be changed to be more active.

4.184 New standards were also suggested, including standards to cover unconscious biases, and the expectation that registrants seek to actively minimise detrimental impacts on others from their practice.

Additional standards

4.185 We received many suggestions for new standards, to include content in relation to:

- willingness to develop IT skills and commitment to seeking support where IT-based skills present barriers to equitable service delivery.
- being prepared to support the education and training of future members of the profession and maintaining linked supervision skills.
- risk assessments for patients.
- Duty of candour, with an explicit reference to responding candidly to investigations where harm has occurred.
- Supporting employing organisations in regularly monitoring and supporting the mental and physical health and wellbeing of staff.
- Informed consent, to cover explaining the benefits, risks and alternatives to a proposed service or treatment.
- Risk of transference, warning against rapport building techniques that increase this risk and setting out what to do when transference occurs
- Professional and appropriate behaviour with colleagues / supervisees.
- Confidentiality between colleagues, for example in a supervisory relationship, making it clear registrants should also be protecting colleagues from unlawful breaches of confidentiality
- Social media, to make requirements more explicit.

4.186 One respondent stated the clinical psychology standards need a reference to neuropsychology, as this is a core element of their training and different to the other psychological professions.

Modality specific standards

4.187 We received many suggestions to amend the modality specific standards. These are set out below.

Clinical psychologists

4.188 One respondent felt it was a missed opportunity to make clinical psychologists skills explicit and distinguish the profession from other applied psychologists.

4.189 Another respondent suggested we add in a clinical psychology standard making reference to building on undergraduate knowledge of how people think, in particular building clinical understanding, rather than seeing it as a separate clinical model. Another said we could refer to clinical psychologists'

ability to deliver appropriate psychological therapies acquired through study and supervised practice and maintained with regular, ongoing supervision.

Counselling psychologists

4.190 Responses included suggested re-writes or additions to the counselling psychology standards in proposed standard 13.

Educational psychologists

4.191 A response from an educational psychologist noted that limited changes had been made to their modality.

4.192 Another respondent suggested re-writes or additions to the proposed educational psychology standards 13 and 14. They considered a greater reference to "evidence base" was required in certain standards and a new standard was needed in standard 13: "Understand the impact of school systems and the educational curriculum, including the legal framework relating to support and funding in schools, on children and young people".

Health psychologists

4.193 One respondent proposed new health psychologist standards within proposed standard 13: "Understand psychological models related to how biological, sociological, and circumstantial or life-event-related factors impinge on psychological processes.

Occupational psychologists

4.194 Several respondents commented on standard 13.51 and noted it referred to the old curriculum. They proposed changes to link this to the five areas in the new curriculum.

Language

4.195 Many responses questioned the language in the standards, arguing that it excluded certain fields of practitioner psychology. One respondent observed "overly medical" language which at times felt "inaccurate/ irrelevant to the profession".

4.196 Several respondents expressed concerns about the changes to standard 2.3, in particular the removal of "assessment, treatment and intervention" and replacement with "diagnostic and therapeutic process". They said that they wished us to retain the original wording and felt that diagnosis is professionally inappropriate for most practitioner psychologists and that many are not trained to do this.

4.197 However, one respondent did welcome the removal of the term "treatment" from 2.3, as they felt this language does not apply to the majority of psychologists.

4.198 Standard 13.4 was also seen to be excluding certain practitioner psychologists. It was suggested that this also needed to include education and community services, rather than just health and social care.

4.199 Other language respondents were concerned with were in:

- Standard 2.4: "maintain high standards of care", as not all psychologists provide care
- Standard 4.2: "initiate solutions", as this implies psychologists are fixing problems and suggests instead replacing this with recommend plans of action
- Standard 14.7: removal of "assessment and interventions" for "diagnosis and treatment"
- Standard 15.1: removal of the "or experience", which suggests a medical / therapeutic relationship which is not the case for all psychologists

4.200 Throughout the document, respondents also questioned the use of "service users, carers and colleagues", rather than terms such as managers, coaches, supervisors, parents/guardians. They also opposed the removal of "as appropriate" in certain standards, particularly those above service user engagement. We also received suggestions to make the level of involvement of service users more explicit, such as standard 9.

4.201 For a couple of standards, respondents wanted more specific language. For example, one respondent requested clearer references to evaluating indirect work in proposed standard 12. Another wanted more specific examples under Standard 14.6.

4.202 Some respondents also commented on the passive language used in the standards.

Relevance to psychology

4.203 Some respondents questioned the relevance of certain standards to psychology. These were:

- Standard 1.2: one response noted that not all psychologists are able to do anything about their workloads
- Standard 15.3: on infection control, which was seen to not be applicable to non-healthcare settings and required specialist knowledge

Other regulatory issues

4.204 One response agreed the changes met the threshold but felt these may present a "greater risk of receiving FTP complaints" and that this might mean registrants are no longer willing to take on this work or may adopt risk averse practice.

Prosthetists / orthotists

4.205 We received one response about the prosthetist / orthotist standards. This came from the professional body, the British Association of Prosthetists and Orthotists. They stated the standards were at "threshold level" with appropriate wording.

4.206 They suggested we add two new standards under proposed standard 14:
- "Be able to conduct neurological, vascular, biomechanical and dermatological assessments in the context of prosthetics and orthotics".
- "Be able to use a systematic approach to formulate a clinical diagnosis".

Speech and Language Therapists

4.207 We received 27 responses about the Speech and Language Therapist standards. 6 were from organisations (3 employers, 1 education provider, 1 charity and the professional body, the Royal College of Speech and Language Therapists) and 21 were from individuals (16 registrants, 4 educators and a non HCPC registered Speech and Language Therapist).

4.208 7 respondents expressed support for the changes. In particular, one respondent felt the changes "made some of the more ambiguous SOPs less so" and "more client-focused". However, the majority provided detailed comments on further changes that they felt were required.

Language

4.209 A common theme across the responses was the language of "be able to" in the proposed standards. Respondents also noted some sections only required "awareness of", which they argued was insufficient for practice. It was suggested that the standards should specify explicit behaviours which need to be evidenced in practice. It was also suggested that we should require registrants "to know" or "to demonstrate" instead.

4.210 However, one respondent suggested that this wording was better suited for practice. They said, *"I particularly like that they use "to be aware of" as we often talk about how we may not experience everything depending on our role in the team but as long as we understand and aware of the process and the research if we ever came across a situation like that".*

4.211 We received some comments about specific terminology used in the proposed standards. For example, a couple of respondents noted the use of "independent practitioner" in standard 9.2 may be confusing as typically this is associated with private practice, and instead suggested "autonomous". Another respondent argued that "impairment" is not inclusive of every service user a speech and language therapist work with, such as transgender and

gender-diverse people. They suggested we instead say "needs" or "voice modification needs".

4.212 One respondent questioned the use of "as appropriate" in certain standards, in particular on proposed standard 8.4 which they felt should be required at all times. They also noted, in relation to proposed standard 8.1, that we cannot always remove every barrier to communication, so the wording doesn't sit easily. They instead suggested we reference "reducing barriers to communication".

Additional standards

4.213 We received detailed comments on the wording of the standards. This included both the generic and profession specific standards. Respondents wanted:

- Greater detail on consent and in particular how to get informed consent, screen someone's capacity to consent and know when and how to make a best interest decision.
- A new standard on escalating issues where service provision cannot meet an identified need.
- Additional standards on keeping up to date, including transcription skills and working with diverse communities.
- Greater reference to electronic / digital competency.
- Reference to professional's recognising they are in a position of power and not abusing this for personal gain.
- Reference to whistleblowing in standard 7.
- Reference to specific legislation such as the Mental Capacity Act 2005 and the Equality Act 2010.
- New standards on making recommendations based on an individual's need, independent of provision available.
- References to service user's home language throughout the standards, including a standard on working to maintain, develop or enhance a client's home language and a requirement a registrant use an interpreter where a client or carer does not share the same language as them.
- Greater emphasis on a service user's cultural, religious and linguistic needs.
- Improvement to standard 6 with the addition of new standards and an emphasis on the active use of practices and resources to challenge implicit biases.
- New standards to ensure registrants can demonstrate knowledge of BAME and LGBTQ+ service users and the challenges they face.
- A new standard on safe delegation in standard 15.

4.214 One respondent called for the re-introduction of deleted standards from standard 8, due to the vulnerability of some of these groups.

Radiographers

4.215 We received 38 responses about the proposed radiographer profession specific standards. 32 were from individuals (23 registrants, 8 educators, 1 non registrant health or care profession). 6 were from organisations (2 education providers, 2 public bodies – Public Health England and NHS England & Improvement (Imaging Transformation Programme, the professional body, the Society and College of Radiographers, and a charity).

4.216 A small number of respondents indicated that they had no further comments and were generally supportive of the amends. The remainder provided detailed comments about the contents of the standards. These are summarised below.

Separation of modality specific standards

4.217 The Society and College of Radiographers noted the "confusing" approach taken for the two professional titles of therapeutic radiographer and diagnostic radiographer. They requested the standards to be separated out, as the roles *"are unique and not transferable across each area due to the significant variation in underpinning knowledge needed for each standard to be achieved"*.

4.218 They highlighted several proposed standards that would benefit from a more separate approach:
- Standard 8.6, as diagnostic radiographers would not be able to advise other healthcare professionals about radiotherapy, whilst therapeutic radiographers would only advise on imaging modalities within the context of their scope of practice within cancer treatment.
- Standard 8.8, as a diagnostic radiographer may have contact with a service user for a diagnostic imaging procedure during their radiotherapy treatment but is not expected to provide information and support for the radiotherapy aspect of their care. The concern was that a service user could read this and have different expectations.
- Standard 9.5, for the reasons outlined above.
- Standard 12.5, to emphasise the difference in regulatory requirements and the quality assurance / control processes for the two modalities.
- Standard 13.8, due to the differences in risk vs benefit in each area of practice.
- Standard 13.9 to remove any opportunity for confusion.
- Standard 14.18 for the same reasons.

The threshold

4.219 We received several comments about certain profession - specific standards, and whether they were appropriate for professionals starting their careers.

4.220 Several respondents, including education providers, questioned standard 13.B, noting students were not permitted to administer oral contrast due to medicines management policies in trusts. They were also concerned about IV administration, as this would mean education providers are in charge of teaching cannulation. One respondent noted this can only be taught in year 2, in line with contrast agents, but may not be maintained within year 3, meaning the skill may be lost on qualification.

4.221 Another respondent noted that not all education courses provide this, both in the UK and abroad, and suggested it would impact current members of the profession. They requested further clarity about this requirement, including what constitutes an intravenous drug and whether fentanyl, anaphylaxis prevention drugs and schedule 2 controlled drugs are considered part of this.

4.222 For the reasons set out above, one respondent suggested we make this clearer in the standards by stating *"be able to administer oral contrast agents, and also intravenous contrast agents when appropriately trained"*.

4.223 Similar concerns were also raised about standard 13.E on AI, with on respondent stating, *"this standard seems to have a high expectation of a radiographer and could be unnecessary to that level"*.

4.224 One respondent questioned standard 14.27 and in particular "minimally invasive interventional procedures". They noted all radiographers that are currently capable of this have clinical or postgraduate training and questioned whether this should be an initial graduate expectation. Another respondent felt that this was too specific and limiting for practice.

4.225 Finally, one respondent questioned standard 14.13 on pathological tests and results, noting students do not have access to patient notes on a regular basis, and sometimes are not permitted a username to access prior details of the patient alone. They said this would therefore require a change to curriculum in teaching about tests and the standard would need to be specific as to what test results need to be known about.

Advanced practice

4.226 A couple of respondents referenced advanced and consultant practice, asking for additional standards to cover these roles. They indicated the standards would allow for standardisation of these roles across boards and countries.

4.227 Another respondent suggested we address "all 4 pillars of advanced practice" from education of students to advanced and consultant practice.

Autonomous practice

4.228 A couple of respondents referred to autonomous practice. One response suggested systems need to be put in place to monitor registrant's ability to

achieve this. Another stated this could be taken as a barrier to qualifying for newly qualified radiographers, as different schools place different emphasis on different areas of practice. They suggested we should have a different standard for newly qualified professionals, like in New Zealand and Australia.

Language

4.229 We received several responses about language used in the proposed standards. We received some suggestions to re-word the standards, to make them easier to read or to better capture the expectations placed on professionals. It was also suggested that certain standards should be merged or deleted where already captured elsewhere.

4.230 One respondent noted that some of the proposed wording was confusing for radiographers, because many terms have a specific meaning in radiation regulation, e.g., "practitioner clinical evaluation". Another response highlighted repetition in the standards and that some language used is not commonly used by students and trainees.

4.231 Similar to issues raised in response to proposed standards for other professions, there was some concern about the use of the word "understand" in the standards. Respondents often felt that this was not strong enough and we needed to add more active language like "be able to apply / demonstrate / perform" where appropriate.

4.232 Additional proposed amendments to the language of the proposed standards are set out below:
- Standard 2.5: personal incompatibility was not considered an appropriate term
- Standard 4.2: one respondent questioned how a registrant would be able to evidence that they meet standards where the phrase "information available to them" was used. The respondent reasons that this would be difficult given that the internet means every piece of information is available at all times
- Standard 4.4: one respondent noted that radiographers don't normally make referrals, and that this wording changes the essence of the point, which is about reasoned decision-making rather than referrals
- One respondent suggested we merge standards 7 and 10 together, and the language needed to be less vague and more active (as you can be aware of something but still breach it).
- Standard 9.7: one respondent felt that by focusing on minimising radiation doses, it didn't cover other aspects of radiographer roles beyond radiation dose.
- Standard 11.2: in relation to the removal of "multi-disciplinary team review", respondents argued that it should be retained. In addition, one respondent noted that "case conferences" only apply to a small group of patients and do not apply to therapeutic radiography. They argued instead

that the term "multi-disciplinary team meeting" would encompass case conferences and would be more inclusive of all professional disciplines.

- Standard 12.1: "engage" was questioned, with one respondent suggesting we instead say, "participate in" and "contribute to".
- Standard 13.6: many respondents questioned what the term "imager" meant and noted this is not widely used.
- Standard 13.12: several respondents questioned what this proposed standard meant or said that it did not go far enough in ensuring safe practice.

Multiple professions

4.233 We received 22 responses about multiple profession's standards. 19 were from organisations (4 education providers, 4 employers, 3 professional bodies, 3 public bodies, 2 trade unions, 2 regulators, and 1 Strategic Health Authority) and 3 were from individuals (1 employer, 1 educator and a response on behalf of the All-Wales Directors of Therapies and Health Science).

4.234 These responses are set out by profession, starting with comments about the generic standards, followed by comments about specific professions' standards.

Generic standards comments

4.235 A few respondents provided general suggestions for the standards which applied across the professions. Many of these aligned with suggestions made in other profession's standards. Requests were made for additional content on:

- A more developed understanding of leadership, including supporting examples
- The principles of delegation and team working, referencing the uniqueness of different professions and the importance of understanding the extent of an individual's scope of practice and professional responsibility
- The development of research skills and the role of registrants as consumers and producers of evidence and research
- Preparedness to support education and training in practice to grow placement capacity
- The safe dissolution of therapeutic relationships
- A more dynamic understanding of digital literacy and innovation and communication and engagement
- Registrants' abilities to oversee and triage care where relevant
- Information sharing, including information governance and confidentiality across digital platforms, principles of disclosure and sharing in a timely manner
- Learning from errors and accepting and apologising when mistakes do occur (to support the duty of candour)
- Record keeping

- Informed consent, including in the context of critical care and safeguarding
- Promoting and protecting service user's interests during end-of-life care
- CPD, in particular linking to the CPD standards and referencing career long learning
- Public health, health promotion and disease prevention and health education
- Health and safety legislation and systems
- Regularly assessing the impact of practice environments on managing risk.

4.236 Respondents requested we review "case conferences" and consider another term recognised across all the professions or refer to "other methods of review", change proposed standard 8.B from "remove" to "reduce" and use of "interventions" as well as "treatments" in standard 14.

4.237 Like the profession specific responses, several responses commented on the language used in the proposed standards. The Council of Deans of Health's response stated, *"a shift of language is needed here and throughout these standards, so the expectation is that registrants not only understand how to undertake certain actions but do undertake those actions when necessary"*. The change to "understand" in proposed standard 2.7 was welcomed, as it indicated that registrants need to acquire a deeper and more contemporaneous knowledge of relevant legislation.

4.238 Suggestions were also made to reorder certain standards or delete standards where they were duplicated elsewhere.

4.239 Responses also referred back to previous questions, such as on mental health and coping strategies. UNISON in particular emphasised the role of employers on this topic and noted these should filter into some of the profession-specific standards, *"where there is a strong emphasis on self-care without mention of support from employers".*

4.240 UNISON's response suggested certain standards, namely proposed standards 3 and 3.1, would be better placed in the Standards of Conduct, Performance and Ethics, whilst Standard 10 from the Standards of Conduct, Performance and Ethics would be better placed in the Standards of Proficiency.

4.241 Public Health England highlighted in their response that significant progress had been made in developing AHPs to be involved in public health. Their expertise has now been recognised in the NHS Long Term Plan as contributing to population health and prevention of ill-health. They proposed several changes to the standards to align with this development:

- Address inconsistent language across the standards on factors affecting health and clinical practice, in particular in proposed standard 5 where we need greater clarity about standards relating to EDI versus standards relating to understanding factors affecting population health.
- Create new standards on the contribution of professions to health promotion / education and prevention
- Address gaps in the standards relating to empowering patients / service users to manage their own health
- Introduce a new standard reminding all AHPs of their responsibility to stay up to date on screenings and immunisations and to move and handle safely to protect their own health and the health of others.
- Address inconsistency and gaps in standards relating to responsibility for own health and the health of the workforce, in particular in relation to proposed standard 3.

Profession specific comments

4.242 Often feedback in these responses aligned with feedback from the profession's standards. We have not repeated any of these points below but instead have set out any additional points raised by this group of respondents.

Arts therapists

4.243 One respondent proposed wording amends to the standards to make the language more active, move away from normative language about health such as "disorder" or "illness", introduce references to co-designing therapy, and move from language of "help" to "support". They also suggested that the standards should refer to arts therapies "integration" with the health and social care sectors, rather than "contributions".

Biomedical scientists

4.244 One respondent stated the standards are set at the threshold level necessary for safe and effective practice.

Chiropodists/ podiatrists

4.245 One respondent provided feedback on these standards. They noted the *"opportunity for HCPC to provide clarity on the future use of the title: chiropodist".* They also reviewed specific language used in the standards, and in particular suggested several amends to remove duplication, allow for a more holistic approach and better reflect the role of the profession.

Clinical scientists

4.246 Three responses provided feedback on these standards.

4.247 One respondent expressed concern with the term "modality" in the clinical scientist standards and said this is *"not widely used or recognised publicly or within the profession and it could cause confusion".* They recommended this

be changed to "speciality/specialities" throughout the standards. They also suggested:

- That as proposed standards 13.3,13.4,15.7 and 15.8 apply to all HCPC registered professions, they could be absorbed into the generic standards.
- Additions to proposed standard 15.6 do not refer to other health and safety issues and so may not apply to all clinical scientists, so recommended we keep the wording in the original standard.

4.248 Another respondent suggested that:

- Physical and mental health should be added to proposed standard 13.1
- The HCPC should clarify the difference between terms like "procedures" and "techniques" and "speciality" and "modality".
- "Depending on modality" should be added to proposed standard 15.8
- There should be greater emphasis placed on safe practice, including the importance of self-awareness, raising concerns and timely interventions to enhance safe practice

Dietitians

4.249 One respondent provided feedback on these standards requesting language changes to provide clarity.

Hearing aid dispensers

4.250 One respondent provided feedback, noting a perceived inconsistency that proposed Standard 13.6 sets out entry requirements for registration with the HCPC, but Standards 1.1, 3.4 and 4, and the HCPC introduction "meeting the standards" make clear that registrants will build on these foundations over time.

Practitioner psychologist

4.251 Two respondents provided feedback on these standards. Both reiterated concerns raised in the practitioner psychologist question on language like "diagnosis", removal of "care" from proposed standard 2.4 and only focusing on service users and carers or health and social care professionals in certain standards.

4.252 One respondent broadly welcomed the proposed changes, in particular noting that the expansion of the focus on equality and diversity and the empowerment of service users within the process reflect the wider societal moves to a more inclusive, informed and co-operative approach. However, they felt proposed standard 7 *"does not fully recognise the ambiguities and nuances required when working with children and young people"* and suggested we introduce a new standard highlighting the limitations of confidentiality when relating to a child, young or vulnerable person.

4.253 They also suggested several new standards/amendments to standards:

- Registrants being prepared and skilled to support the education and training of future members of the profession to ensure public protection and workforce supply.
- For clinical psychologists, understanding and being able to act on and provide advice on policy concerning health and care.
- Reference to defined levels of competence (in standard 14.39 of the table of proposed amendments) to address lack of clarity regarding the level of competence that clinical psychologists have in specific NICE recommended therapies.

4.254 The other respondent made comments in relation to the standards' references to:
- employer duties or contextual implications of working in strained and stressed services.
- anti-discriminatory or anti-racist training
- the use of interpreters.
- robustness of leadership references
- the removal of "*evaluate practice systematically and participate in audit procedures*".
- The "extensive listing of various standards, some of which may simply not be possible if one is working in a specialism which means that a clinician could know a huge amount about a specific area".

Occupational Therapists

4.255 One respondent provided feedback on these proposed standards. They suggested certain standards be re-worded, re-ordered or merged and suggested we should clarify our use of certain language ("relevant behavioural sciences"). They also proposed Standard 13B become a generic standard.

Operating Department Practitioners (ODPs)

4.256 One respondent provided feedback on these standards. They reiterated calls from certain ODPs to increase the education threshold to degree level. They also suggested we widen the scope of two standards, 13.15 and 14.C so they refer to ODPs being able to participate in the management of clinical emergencies and cover more than just the "initial management" of service users undergoing cardiac arrest. They also suggested standard 11A become a generic standard.

Orthoptists

4.257 One respondent provided feedback, proposing certain standards be reordered to appear higher up in their sections, due to their importance.

Paramedics

4.258 One respondent provided feedback on the proposed standards. Respondents suggested wording amends to improve readability or clarity of the standards,

as well as additions to cover safety netting and decision making and the integrated roles for paramedics working with other professionals in health and social care.

Physiotherapists

4.259 One respondent provided feedback. On proposed standard 13 which they felt needed to "fully encompass the contemporary knowledge base and role of physiotherapists" and ensure terminology is up to date and not "based too much on the bio-social-psychosocial model". They also suggested including a reference to health and social care systems, health promotion and health informatics in Standard 13 and proposed we implement a new standard to cover registrants' abilities to supervise students.

Prosthetists and Orthotists

4.260 One respondent provided feedback proposing amendments to cover prescribing treatment plans of any device, the biomechanics of gait and interventions, and fit aspect and review, understanding the biomechanics of gait and interventions, making appropriate referrals and moving and handling legislation.

Radiographers

4.261 One respondent provided feedback and proposed removing duplicate standards and merging certain standards *"to better reflect the holistic approach that radiographers deliver in practice*". They also suggested re-ordering or rewording certain standards, as well as adding references to patient judgement, differing risks for the modalities, and limiting exposure from radiation.

Speech and Language Therapists

4.262 One respondent provided feedback suggesting amendments to the language used in the standards to better represent the profession's work and proposing new wording on certain standards. This included in standard 14. changing from "developmental speech and language impairments" to "developmental speech and language disorders", "fluency impairments" to "dysfluency", "swallowing impairments" to "dysphagia" and "voice impairments" to "voice disorders". Similarly, in standard 13.10 they suggested the word "normal" be changed to "typical."

4.263 They also suggested moving certain standards, or parts of standards, into different sections. For example, they suggested that proposed standard 5.2 should be moved to sit within proposed standard 8.

4.264 Finally, they suggested we note that not all individuals with communication difficulties have difficulty with swallowing and vice versa. This was particularly so for standard 14.18 which they recommended we clarify and potentially split

in two as communicative functioning and swallowing status are not
necessarily linked.

Additional standards

4.265 Many respondents proposed additional content for the standards, they wanted
to see:
- Reference to valid consent rather than just informed consent.
- Reference critical thinking in proposed standard 4.
- Enhancement of the current standard on legislation so it also covers
knowledge around governance processes that embed legislation in
practice, e.g., regulation, statutory guidance, professional and other
national body guidance and employer level / local policies and procedures.
- Greater emphasis on learning, CPD and learners in the workplace. This
included stronger wording to ensure all registrants actively engage in
learning and enhance the experience of learners to support the future
workforce, as well as actively engage with the learning environment and
experience.
- New standards on delegation and demonstrating the skills to mentor,
coach and support colleagues.
- Return of nuclear medicine content in the profession-specific standards to
avoid a negative impact on future services.
- A new standard on involving service users in service design and delivery,
education and research.
- Reference to the IR(ME)R 2017and regulatory requirements in standard
12. [5]
- A new standard on understanding the philosophy and principles involved
in the practice of both modalities.
- A new standard on understanding the harms and benefits of population
and targeted health screening.
- Reference to legislation in the context of the administration of drugs.
- Amendment to proposed standard 12 to include links to governance
processes
- Reference to scope of practice within certain standards.

Diagnostic Radiographer standards

4.266 One respondent asked for more emphasis on CT and MRI skills, noting these
are "hugely expanding areas of practice" and are "likely to be for the
foreseeable future".

4.267 In relation to nuclear medicine, one respondent stressed the importance of
radiographers being aware of the scope of nuclear medicine and the wide

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[5] The Ionising Radiation (Medical Exposure) Regulations 2017:
https://www.legislation.gov.uk/uksi/2017/1322/contents/made

range of techniques available. They noted that this goes beyond Gamma Camera Imaging, covering conventional and PET-CT imaging and inclusion of associated therapy techniques. They proposed changing standard 14.34 to "be able to assist with imaging and therapeutic procedures involving the use of radionuclides including PET tracers and particle emitters".

4.268 One respondent questioned the phrase in standard 14.27 "broad range of standard imaging techniques". They questioned what this means and indicated it could result in different levels of competency amongst students. Instead, they suggested that the standards could define different pathways into the profession and state the core examinations that would be associated with that pathway (e.g. general radiographer - major trauma, general out and in-patient work, mobiles, theatre, fluoroscopy; MRI radiographer - MRI of the head, IAMs, spine, extremities etc).

4.269 However, the Society and College of Radiographers indicated this standard was designed to "support a more flexible approach to producing a radiographer that meets service need and can adapt to emerging technologies and techniques". They suggested proposed standards 14.31-35 be deleted, as they do not cover all current or emerging technology e.g., mammography, DEXA, or PET imaging.

4.270 A couple of respondents suggested we strengthen proposed standards 14.32-33, noting undergraduates can perform cross sectional imaging upon graduation, and assistant practitioners within England can practice these skills with correct training if it is within their scope of practice, so those going into the profession should be the same level.

4.271 The Society and College of Radiographers proposed several additional standards, as they felt the current standards do not encompass the full scope of practice of the profession. These covered examinations, appropriate care and diagnostic care pathways, and the full range of pathways. Their proposals stated that radiographers must be able to perform certain diagnostic imaging techniques, minimally invasive interventional procedures, and contrast agent examinations. We were also asked to consider a new standard on providing appropriate care for the range of service users, their carers' and relatives before, during and after imaging examinations, minimally invasive interventional procedures, and contrast agent examinations.

Therapeutic Radiographer standards

4.272 The Society and College of Radiographers noted that the proposed therapeutic radiography standards are "representative of changes being made within pre-registration education", such as MRI involvement, interprofessional education and training, holistic care assessment, increased planning theory and practical applications. They therefore supported these changes, subject

to further minor wording amendments. In general, these were to clarify the remit of the standards or to better reflect current practice.

4.273 It was also suggested that we reorder certain standards so that they follow the patient pathway (pre-treatment to treatment), to improve clarity and readability.

4.274 In relation to nuclear medicine, one respondent noted that the therapeutic radiographer standards do not mention nuclear medicine. They noted that their department is made up of 1/3 therapeutic radiographers and stressed the importance of future recruits knowing about this. They suggested we add in a new standard in standard 13 of "Understand the principles of Radionuclide procedures in Radiotherapy including NM SPECT-CT and PET-CT guided planning and Radionuclide Therapies and Theragnostics."

Question 7: Do you have any comments on the proposed amendments to the preamble and glossary to the standards of proficiency?

4.275 We received a total of 166 responses to this question.

Summary

4.276 Most respondents provided no comments on the preamble or glossary (101 responses, 61%).

4.277 A further 23 responses (14%) stated they agreed with the amendments, indicating they were "more reader friendly", "helpful in improving understanding of the purpose and uses of the SOPs", "clear and concise" and "a good reminder of how the standards complement individual professional standards".

4.278 37 responses (22%) provided detailed comments on the preamble and / or glossary. These either related to language used, terms in the glossary or other regulatory issues unrelated to the standards specifically. These are set out below.

4.279 The final 5 responses either stated "yes" but provided no comments (3 responses) or were blank / incomplete (2 responses).

Comments

4.280 Below is a summary of the suggested amendments to the preamble and glossary raised in the 37 substantive comments to this question.

Accessibility of language

4.281 We received two comments on language used in the preamble. One comment stated that wording was not in plain concise language, but "management-talk".

Another said that "service users should not have to refer to a glossary to easily understand what is meant within the standards".

Use of "be able to" and "understand"

4.282 We received two comments about the use of language like "be able to" in the standards. One respondent asked us to differentiate between "be able to" and "understand", noting in particular proposed standard 15.8 in their profession's standards, relating to sterile fields, which currently uses the language of "understand". They argued that it is essential registrants acting as scrub practitioners are able to set up and maintain a sterile field.

4.283 Another argued that the word "understand" can be interpreted in many different ways and mean different things to individuals. It could be described as only surface learning (recall/comprehension of information) or deep learning (being able to apply, appraise and synthesise this knowledge). They therefore suggested that we define what is meant by understanding within these standards.

4.284 One respondent questioned the language of "be able to" and what this means for students and registrants. The response noted that we have explained this is so the standards remain applicable to both students who are not yet registering and current registrants. They argued that this could suggest students who are only "aware" or "able to understand" may be eligible to register, which, they said, was not the case. They also argued *"if the standards of proficiency are supposed to reflect the level of proficiency required to register, should they not use language such as "be able to"?"* They argued that this would set aside those who meet the standards of proficiency from those who are trainees (and therefore not yet expected to meet the standards of proficiency).

Scope of practice

4.285 We also received a question about how the standards relate to registrant's scope of practice. There was some confusion about our statement in the preamble that the standards must be met to join the Register, but registrants only need to meet standards relevant to their scope of practice. This response argued that, if this was the case, the standards should not be labelled "standards of proficiency" and instead should only include standards all registrants in that profession must meet.

Glossary terms

4.286 Just under half of comments to this question (49%) discussed the glossary and suggested we change or add terms to it, in particular definitions for:

- Modality.

- Service user.

- Safeguarding.

- Stakeholder.

- "Diagnostic" and "assessment", explaining why HCPC uses one word or the other.

- Supervision.

4.287 We were also asked to revise the definitions of the following:

- Inclusive - use "equitable" rather than "equal", to provide for the fact some service users might require special provision and therefore not be treated equally

- Consent – respondents suggested that the current phrasing could be taken such that treatment is given by a service user or someone acting on their behalf, so instead re phrase to *"After they have received and understood all the information, they need to make a decision; consent is permission given by a service user or someone acting on their behalf, for a registrant to provide care, treatment or other services."*

- Leadership - referencing feedback provided in the earlier leadership question

- Case conference - Remove the term and replace with Multi-Disciplinary Team meeting (MDT), with a case conference used as an example

4.288 One respondent noted that the fact that "child/ children" were defined separately to "service user" but the term "service user" is used for both adults and children which was somewhat confusing.

4.289 Two respondents noted that the glossary contains words not actually used in the text of the proposed standards. This included "apologising" and "delegate".

4.290 Some respondents made general comments about the length of text. One response said the preamble is "somewhat long".

Other regulatory issues

4.291 As with other questions, some responses also used this question to raise other regulatory issues, these will be considered separately to this review.

Question 8: Do you consider there are any aspects of our proposals that could result in equality and diversity implications for groups or individuals based on one or more of the following protected characteristics, as defined by the Equality Act 2010?

- **Age**
- **Disability**
- **Gender reassignment**
- **Marriage and civil partnership**
- **Pregnancy and maternity**
- **Race**
- **Religion or belief**
- **Sex**
- **Sexual orientation**

4.292 The vast majority (173) of consultation respondents selected no, 39 respondents answered this question affirmatively ("yes"), with 20 of those responses filling in the free text comments box. 57 respondents selected "don't know."

No

4.293 12 of the respondents who selected "no", reported that:
- The revisions are an improvement and strengthen this aspect
- Cultural sensitivity and BAME guidelines need to be emphasised.
- The document is very wordy and loses clarity due to this.
- It is *"good to change to 'inclusive' rather than 'non-discriminatory'"*

Don't know

4.294 Of the 57 respondents that selected "don't know," eight left free text comments. In which there were no discernible themes.

Yes

4.295 Just over half (11) of respondents who said yes provided comments, repeating feedback that they had provided in response to the previous question one, including that:

- The wording is not strong or robust enough/is too passive throughout the standards. Stressing that it's not enough to "be aware" or "understand"; it needs to be specified that practitioners must be respectful, accepting and supportive with those who are different. It is not only about understanding but is also about being sensitive and actively promoting equity.
- One respondent shared their view that the standards do not make explicit the need for registrants to be actively challenging their own views, addressing their own implicit biases, and offering services that actively seek to understand and work with the clients lived experience.

- One respondent stated they would "resist any approach that prescribed training in "cultural competency" but rather would be promoting cultural humility and curiosity."

4.296 Four respondents highlighted the lack of direct reference to LGBTQ+ and BAME; reporting that *"the level of discrimination is still very high and corrosive and must be directly addressed by HCPC."*

4.297 One respondent raised the importance of differentiating between protected characteristics in the Equality Act (2010) and other characteristics not included in Law and how they relate to proposed standard 5.B… *"standard 5.1 would benefit from ensuring all above protected characteristics are included…standard 5B should also include marriage and civil partnership alongside the other protected characteristics."* Another respondent stated that it should include paternity and other inclusive parenthood options.

Disability

4.298 Five respondents referenced potential negative impacts in relation to disability, stating that the technology, communication, and digital skills standards may have implications for people with certain disabilities and learning difficulties. These respondents also indicated that neurodiversity needs to be included and one respondent indicated that it should cover "any conditions impacting on communication or capacity."

4.299 Two respondents indicated the need to clarify that the level 7 English proficiency standard can be met with the use of assistive technology as would be an appropriate adjustment for dyslexia.

4.300 One respondent highlighted that (prospective) registrants have concerns about the impact of their mental health condition on their ability to practice and seek advice as to the support they will likely require. This respondent called for more examples which relate to mental health and practice, to be provided by the HCPC in guidance. This respondent also queried whether individuals with mental and physical health difficulties have been involved in this review of the SOPs.

4.301 Another respondent similarly stated that they think there should be an additional section that covers the need for registrants to be aware of their needs in relation to their mental and physical health; when and how additional support is required; and how to ask for such support.

Age

4.302 One respondent stated that they think there will be a negative impact in relation to the protected characteristic of age but didn't elaborate as to why or how. Another respondent also identified age and added that different stages of life can present challenges (for example, caring for a disabled child or parent / the

menopause), when an individual may require extra support to meet standards of practice.

4.303 One respondent commented that there can be impacts by age, especially for children - this respondent specifically referenced children's rights, consent and protection from abuse.

4.304 Another respondent said that age could possibly play a factor in the adoption of new technologies, and gave the example of virtual consultations via video, and a move to more online working, which they noted did seem to be disproportionally harder for older members of the workforce, both cognitively and visually. This respondent also highlighted the need for those individuals to adapt.

Race

4.305 One respondent stated that the need to speak English to the required level could potentially discriminate against Welsh speakers who live and work in Welsh speaking areas in the UK.

4.306 Two respondents made comments relating specifically to the Speech and Language Therapist (SLT) profession and made points about multilingual settings for their service users. One noted that English language competency is insufficient where a client's first language is not English, and so instead the emphasis needs to be on community awareness. Another highlighted that the standards have now become too generic and need to challenge *"the white western-centric model that pervades most of our evidence base for how children learn language and what "good" parenting looks like"*. This respondent suggested that the standards should actively remove barriers that discriminate against children from households that are multilingual or where parenting practice is communal.

Question 9: Do you consider that our proposals are proportionate to our role to protect the public, and represent the threshold level necessary for safe and effective practice?

4.307 The vast majority of individual respondents (80%) and the majority of organisational respondents (55%) believed our proposals to be proportionate to our role in protecting the public and represent the threshold level necessary for safe and effective practice. Only 5% of individual respondents and 6% of organisational respondents did not believe that these proposals adequately did so. 8% of individuals and 31% of organisations chose "don't know".

4.308 A quarter of respondents provided comments in response to this question. We have only featured new comments in the analysis of this question. Where

respondents used this question to reiterate points that they made elsewhere, these are not addressed here but are covered under the original question.

Writing Style, Wording & Presentation

4.309 Several respondents made comments about the writing style & presentation of this proposal and the standards in general. Some commented on the breadth of the proposals; with a few indicating shorter, more succinct standards would assist registrants to translate them into practice.

4.310 Some of these respondents made suggestions concerning the wording of the standards; one respondent felt that the use of flexible and enabling wording made the standards too generic and that they were therefore not specific enough to ensure good practice.

Flexibility & Adaptability

4.311 Some respondents expressed concerns that the current proposals were not flexible enough to adapt to changes in practice. One organisation felt that more consideration needed to be given to the ways in which practice has changed in the past six months, due to the Covid-19 pandemic, as well as the likely changes that would come in the future as a result of this.

Safety Concerns with Drug Administration and/or Equipment

4.312 A few respondents expressed concerns over the lack of adequate reference to the safety of certain aspects of practice. These aspects included: drug administration and prescribing, intravenous drug administration as well as automatic external defibrillator (AED) and other defibrillator use.

Other concerns

4.313 Some respondents noted issues with equality, diversity & inclusion were the reason they did not consider our proposals were proportionate to our role to protect the public and did not represent the threshold level necessary for safe and effective practice. However, no specifics were given concerning this (likely, as a result of covering these points elsewhere in the consultation, for example in response to question 8).

4.314 Two respondents felt that more clarity had to be given to registrants regarding informed consent and its overall role in protecting the public/service users.

4.315 Health and wellbeing was a prevalent theme in the comments from some respondents. Many respondents felt insufficient emphasis was given in the standards to health and wellbeing of the registrants, however, one respondent applauded the proposal for its mention of registrant health and wellbeing, positing that they found this to be a "great addition".

4.316 A few respondents alluded to other considerations, including supervision, delegation, education, and training, safeguarding and the complaints

procedure. However, these have been referenced in previous sections, so will are not repeated here.

Question 10: Do you have any additional comments about the standards of proficiency?

4.317 This was an optional question which nearly half (47%) of the respondents answered. Many organisational responses applauded the HCPC on their work and/or indicated their commitment to collaboration with the HCPC. Respondents did however raise a number of topics in their responses to this question, which are set out below:

Writing Style, wording & presentation

4.318 Several respondents made comments regarding the writing style, wording and presentation of the consultation document, most of which, echoed the comments given in response to question 9.

4.319 One respondent suggested that there needed to be consistency between the terms "autonomous practitioner" and "independent practitioner", as the former was used in the generic standards and the latter in the profession-specific standards.

4.320 Additionally, another respondent also suggested that more definitions should be added to the glossary of the standards.

Supervision & Delegation

4.321 Some respondents raised a concern over the lack of adequate mention of supervision and/or delegation. In terms of delegation, all respondents that commented on this matter felt that more explicit reference was required. Some respondents also believed more emphasis could have been given to supervision in the standards.

Education & Training (including CPD)

4.322 Several responses made reference to the topic of education and training, which also included Continuous Professional Development (CPD). Respondents suggested that there should be an additional standard to necessitate the responsibility of current registrants to adequately train new registrants and students, or that this should be covered in one of the existing standards.

Equality, Diversity & Inclusion

4.323 Several individuals and organisations made reference to EDI matters in their responses. One organisation felt it was important for the HCPC to embed equity, equality of outcome, diversity and positive social change in all of its standards, to ensure results.

IELTS

4.324 Two respondents addressed their concerns over the current requirements for International English Language Testing System (IELTS) results. One individual commented specifically on the requirements for Speech & Language Therapists, stating that the level 8 criteria was too strict. Additionally, in relation to the level required for speaking in other professions, another respondent commented that IELTS band score of 7 (or score of 6, with one of the subtests), should be accepted, as they believed that it would not affect the quality of service.

5.   Our comments and decisions

5.1   We have carefully considered all of the consultation responses, feedback received during Service User Engagement Workshops and our Equality Impact Assessment. We have used them to inform the revisions we have made to the standards.

5.2   Following the round of revisions made after the consultation, we conducted a further round of engagement with professional bodies and education providers. In these engagements we asked for input on our proposed standards, with a special focus on whether the revisions were threshold for the different professions. We also wanted to ensure that all of our education providers would be able to deliver programmes which were able to assess the proficiencies in the proposed standards.

5.3   The following section sets out the decisions we have taken which underpin the content of the final standards.

5.4   In this section we make reference to numbering of our proposed final standards. The standards for each profession (which include the generic standards) can be found at annexure D. A table comparing these final standards against the standards taken to consultation can be found at annexure E.

Language in the generic standards

5.5   We received many comments about the use of passive language in the standards. Respondents were concerned that this might cause confusion and could undermine fitness to practise investigations, as registrants could evidence that they have met the standard because they understand the concept without actually being able to do it in practice

5.6   Having considered these comments further, and having reviewed the approach taken by other regulators, for example the Nursing and Midwifery Council, we agree with the feedback we received from respondents. In particular, we want to avoid the situation where a registrant is able to join the register without being able to … as this could represent a risk to public safety.

5.7   We have therefore decided to change the wording of the standards, so that they now open with the line *"At the point of registration, registrants will be able to:"*. The standards then follow on from the above. This allows the language of the standards to be much more active and clarifies our expectations of registrants being able to do the things set out in the standards at the point of registration.

Equality, Diversity and Inclusion (EDI)

5.8   We received detailed feedback about our Equality, Diversity and Inclusion standards. In response, we have introduced several new standards which cover:

- Equality legislation.
- Personal biases (which may be unconscious) and the need to ensure these do not affect the treatment of others.
- An expanded approach to the protected characteristics, which moves away from listing the protected characteristics, which we felt might encourage a narrow reading of the standards, and instead requires the consideration of "differences of any kind" which includes the protected characteristics and intersectional experiences.
- The duty to make reasonable adjustments, which includes supporting others to make these.
- The impact of a person's characteristics on their health.
- Reference to EDI in our standards on leadership.
- Recognition that EDI needs to be embedded across all areas of the standards and practice

5.9   We have also merged standards 5 and 6 into one section on EDI.

5.10   We received many requests for the standards to provide more detail, including standards on specific protected characteristics or training requirements. We've aimed to strike a balance between providing greater detail, to make our expectations clearer, and ensuring our standards remain outcome focused, at the threshold stage, and are not overly prescriptive.

5.11   Registrants are required to read these standards in the round, and therefore embed the EDI standards across all areas of practice. This is one reason we have not included specific EDI standards within each section of the standards as this could create the impression that sections without an express EDI provision meant that there was no duty in that respect.

5.12   When we say that registrants are required to read the standards in the round, we are also referring to a wide range of other sources which support the implementation of the HCPC's standards. These include guidance provided by the HCPC itself but also to resources from employers, professional bodies and education providers. Amendments to our preamble should help registrants understand how they are to read and apply the standards in their practice. We will also be producing supporting guidance following publication that will include detail on EDI.

5.13   We will continue to work with a wide range of stakeholders as we develop more guidance and other supporting materials for these standards.

Service user involvement

5.14 During early consultation, we received feedback that the voices of service users needed to be strengthened in our standards and we have made several changes to the standards to strengthen our position on service user involvement. We have proposed these changes as part of our wider support for service users playing an active role in the provision of their health and care and our belief that increased service user involvement will have a positive impact on public safety.

- A strengthened standard on consent, referencing the need for this to be informed and valid, with due regard for mental capacity (Standard 2)
- Strengthened expectations on confidentiality and record keeping (Standard 7)
- Reinstated our communication standard on the use of interpreters (Standard 8)
- New standard on identifying stress and anxiety in others (Standard 9)
- A new standard on engaging service users in research (Standard 14)

5.15 We received concerns from some professions, who are not traditionally service user facing, about how they will meet some of these standards (for example, biomedical scientists). While we understand these concerns, we think that it is important to continue to strengthen our approach towards consent.

5.16 We are confident that even with these changes, all of our registrants will be able to meet their standards of proficiency This is because all our standards are outcomes-focused and need to be demonstrated in a way that is relevant to an individual registrant's scope of practice.

5.17 We will be working with affected professions to establish how our supporting guidance on the SOPs can take roles like these into account.

Maintaining fitness to practise

5.18 We have taken into consideration respondents' concerns that conflating mental health with maintaining fitness to practise could have a negative impact on registrants seeking out support.

5.19 We have decided to re-word standard 3 so it is now solely focused on registrant health and wellbeing, rather than fitness to practise. This aligns with the approaches of other regulators, such as the General Medical Council.

5.20 We believe that the requirement to maintain fitness to practise is captured in existing standards under standard 2: "practise within the legal and ethical boundaries of their profession" and, more specifically, standard 2.4: "understand what is required of them by the Health and Care Professions Council, including but not limited to the Standards of conduct, performance

and ethics". Some respondents asked us to define fitness to practise. This definition exists in [other HCPC documentation](#) about our fitness to practise process.

5.21   We have also re-worded many of the standards under standard 3, in light of feedback. This includes changing "coping strategies" to "wellbeing strategies" and including new standards on registrants identifying stress and anxiety in themselves and others and adopting strategies for physical and mental health, self-care, and self-awareness. These standards were originally from the proposed profession specific standards for ODPs and the standards for paramedics respectively.

5.22   By introducing a new standard on identifying stress and anxiety in others, we hope to address concerns raised by respondents about the difficulty of sometimes self-identifying when you are struggling and need help. We hope this standard will encourage a more supportive culture within organisations and improve access to mental health support.

5.23   We have also introduced other standards across the SOPs that support health and wellbeing, including referring to the emotional burden of workloads in standard 1 and changing the language in standard 11 from reflection to reflective practice.

5.24   We did receive feedback about the role of employers in supporting mental health. We will be working closely with employers in the implementation of these new standards. Working with others to support health and wellbeing is also a key focus of our Corporate Strategy and our Registrant Health and Wellbeing Strategy.

Technology and digital skills

5.25   We have made changes to the standards relating to technology and digital skills. These include new references to digital technology in standard 7 and 8, on confidentiality and communication, and a new standard on using digital record keeping tools where required in standard 10.

5.26   More detailed standards on technology and digital skills have been added for certain professions, but we recognised that there was significant variation in different practice settings and professions. In the interest of keeping the standards at threshold level, we have therefore focused our changes to generic standards on the above broad areas, as opposed to introducing more detailed requirements.

5.27   Use of technology and digital skills is an area we will continue to revisit in future reviews of the standards. Our standards are outcomes based and broadly worded in general. This is an important consideration for standards

relating to technology where language which was too specific may result in standards quickly becoming obsolete as technology continues to develop.

Leadership

5.28 In general, respondents asked us to introduce more detailed standards on leadership or noted that the wording of our standards relating to leadership may not have found application across all roles.

5.29 We have changed the definition of leadership so that it is now clearer that this is a skill which all professionals can demonstrate, at all levels.

5.30 We have also introduced several new standards on leadership. These require registrants to:

- recognise that leadership is a skill all professionals can demonstrate (standard 8.7);
- identify their own leadership qualities, behaviours and approaches, being mindful of the importance of equality, diversity and inclusion (standard 8.8);
- demonstrate leadership behaviours appropriate to your practice (standard 8.9);
- act as a role model for others (standard 8.10); and
- promote and engage in the learning of others (standard 8.11).

5.31 We will be issuing further guidance on leadership on our website, to support registrants to implement these standards.

Other changes to the generic standards

5.32 We have introduced a new section on public health for all our registrants. These standards cover:

- Understanding their role in health promotion, education and preventing ill health
- How social, economic, and environmental factors influence a person's health and wellbeing
- Empowering and enabling individuals to manage their own health
- Engaging in occupational health, including an awareness of vaccination requirements

5.33 Many of these public health –related standards already exist in the current version of the SOPs for our professions. However, the pandemic has highlighted the importance of public health, the impact health inequalities can have and the role all health and care professionals can play, and so we wanted to emphasise the importance of public health by creating its own section.

5.34 We recognise that the role our professions will play in public health will vary and look very different for non-clinical professionals. The language of the new standards is focused on understanding the role of their profession and registrants will need to demonstrate these as far as they relate to their scope of practice.

5.35 We have also re-worded the English Language standard in the generic standards, to reference the required standard for the profession rather than a specific level, due to the confusion caused by the higher level required for Speech and Language Therapists.

5.36 Throughout the standards we have also made various wording amendments, either to clarify the meaning of certain standards or to update language or make it more in keeping with all our professions.

5.37 We have also aligned the wording of certain standards with the Standards for Conduct, Performance and Ethics (SCPEs) and expressly mentioned the role of the SCPEs under standard 2. This was in response to many respondents questioning why we did not cover certain topics in the Standards of Proficiency, which are covered in the SCPEs. It is important that both sets of standards are read together and registrants are able to demonstrate both in their practice.

Profession-specific standards

5.38 Following the end of the public consultation in October 2020, we have undertaken significant further engagement with a range of stakeholders, with a specific focus on education providers and professional bodies. While this was another opportunity for these stakeholders to give input on the standards in general, we also asked for their feedback on specific issues that may have been raised by other consultees. This was a large scale, iterative process, carried out simultaneously across the 15 different professions.

5.39 Through the thorough and consultative process, we have taken, we are confident that the standards we are proposing are deliverable by education providers, achievable for registrants, reflect the current threshold of practice for each profession and ensure safe and effective practice for service users.

5.40 We have considered each profession's standards on a case-by-case basis taking into account the consultation responses. The number of changes to the proposed profession- specific standards we have made varies by profession. While some profession's standards have remained largely the same (practitioner psychologists, for example), as a consequence of the consultation process more changes have been made to others (such as radiographers). This document summaries the key changes for each

profession. A full list of all of the amendments we have made can be found in the table of proposed changes annexed to this document. Where we have received significant feedback on an issue but have decided not to make a change, we have also provided that rationale

5.41 The standards for different professions have also changed in line with changes to the generic standards we have outlined above. For instance, each profession's standards have changed so that the wording is more active. There have also been changes made where we have brought profession-specific standards into line with our commitment to leadership and to equality, diversity, and inclusion.

5.42 In light of the responses we have received, we have decided not to implement some of the changes to the standards that we consulted on where these changes would represent requirements that were set above the threshold level for individual professions. Decisions on what constitutes threshold level have been reached following detailed additional consultation and engagement with the relevant professional bodies and key stakeholders including employers and educator providers across the four UK nations.

Arts therapists

Language

5.43 Respondents to our consultation suggested that we should bring the language in our standards up to date with socio-cultural perspectives on therapy. They also suggested that we should make the standards more inclusive.

5.44 An example of the change we have made in light of this feedback followed on from our engagement with various course coordinators of drama therapy programmes in the UK. The coordinators suggested that we should amend standard 13.28 to include reference to 'many different cultures and traditions' instead of 'different histories in Eastern and Western Europe and the Americas'.

5.45 This change to wording which acknowledges the contributions made to the professions by those outside Europe and the Americas and is an example of the standards reflecting contemporary practice and inclusive language.

Biomedical scientists

Consent

5.46 Consultation respondents raised concerns about the ability of biomedical scientists to meet the generic standard we proposed on service user consent. Following this consultation and further engagement with professional bodies, we have decided not to amend this standard. We will instead develop

guidance which will clarify our expectations for registrants who are not in service user facing roles.

5.47   While scope of practice considerations mean that this standard is threshold for biomedical scientists at present, we are also mindful of future-proofing the standards in the event that biomedical scientists increase their interactions with service users through broadening their scope or by increasing their medical entitlements.

5.48   As the standard is about being able to understand and obtain consent, it is something a registrant would only need to demonstrate if they are in a role where obtaining consent is required. For those working solely in laboratories, this consent might not be direct but would be about understanding the concept of consent and its importance more generally. If a biomedical scientist subsequently moved into another role (for example, as part of a vaccination programme) then this standard would be more relevant to their scope and practice, and they would have to ensure their service users had consented to that vaccine

Service user versus patient pathways

5.49   In line with a general change in terminology across the standards, we have changed references of 'patients' to 'service users' in the profession-specific standards for biomedical scientists.

Authorising results

5.50   In the light of the consultation responses and further engagement with professional bodies, we have proposed an additional standard (13.31) relating to biomedical scientists being able to perform and interpret investigative tests and authorise laboratory results they have generated.

Clinical scientists

Use of 'modalities'

5.51   Although they are regulated as a single profession, clinical scientists practise within discrete disciplines known as "modalities" and some requirements in these standards are modality specific. Following engagements with Health Education England, we have agreed to add to our definition of the term 'modalities' in the footnote to standard 11.7. This footnote explains how modalities for clinical scientists are not directly linked to a title on the register, in contrast to other professions.

Chiropodists/podiatrists

5.52   Aside from general changes to wording in line with the standards, we are not proposing significant further changes to the standards for chiropodists and podiatrists.

5.53 We have reached this decision after analysing the consultation responses and following specific engagement with the relevant professional bodies and education providers.

Dieticians

5.54 Aside from general changes to wording in line with the standards, we are not proposing significant further changes to the standards for dieticians.

5.55 We have reached this decision after analysing the consultation responses and following specific engagement with the relevant professional bodies and education providers.

Hearing Aid dispensers

5.56 Aside from general changes to wording in line with the standards, we are not proposing significant further changes to the standards for hearing aid dispensers.

5.57 We have reached this decision after analysing the consultation responses and following specific engagement with the relevant professional bodies and education providers.

Occupational therapists

Holistic care

5.58 Our proposed standard 12.16 included wording requiring registrants to "provide service users with holistic and person-centred care". Feedback in response to our consultation indicated that there was confusion about how to demonstrate "holistic person-centred care."

5.59 Following engagement with professional bodies, instead of using the wording around "holistic and person-centred care" we have instead included factors which registrants can take into account when delivering care, including physical, biological and social factors.

Operating department practitioners

Service users' elimination needs

5.60 We propose the standard for ODPs is changed from the need to 'understand' the procedure of catheterisation for service users, to being able to 'undertake' this procedure, in line with our consultation.

5.61 This change was an important element for professional bodies and other stakeholders during pre-consultation processes and ensures continued alignment of the skills of ODPs with other AHP colleagues.

Surgical first assistant

5.62 As detailed in the consultation response analysis, while there were some calls for ODPs to 'be able to undertake' the role of surgical first assistant, we have decided to not make this change and to retain wording which requires ODPs to 'understand' the role of surgical first assistant.

5.63 This is partly due to the fact that the roles of surgical first assistants are varied across different parts of the UK (some nations of the UK and various regions of England do not make use of the role at all). This would make it very challenging for some education providers to provide experience in this role, partly due to a lack of placement opportunities.

5.64 We were concerned that such a variation would make it challenging for all education providers to meet this new standard. We understand that this would be particularly challenging for Diploma of Higher Education (DipHE) programmes. As Scotland's only accredited ODP programme is at DipHE level, this variation would also have specific impacts on that country and present a problem for the HCPC as a UK-wide regulator.

Preparation and delivery of drugs

5.65 Standard 13.17 requires ODPs to be able to prepare and administer drugs to service users via a range of routes, including oral, rectal, topical and by intramuscular, subcutaneous, and intravenous injection.

5.66 At consultation this standard included the phrase "prescribed drugs." Following consultation, we have removed the word "prescribed" from the above standard as its inclusion could create the impression that this standard related to Prescription Only Medicines or to prescribing rights in general.

5.67 With a focus on skills required to administer drugs, we consider that this standard is at threshold level.

Understand common abnormal blood physiology

5.68 At consultation we proposed a standard which included elements of theory and skills relevant to working with blood.

5.69 Following consultation, we have decided to split this into two separate standards: standard 13.19 which sets out "understand common abnormal blood physiology, including blood gas analysis"; and a new standard 13.20 which sets out "undertake venepuncture, peripheral IV cannulation and blood sampling" This does not change the substance of the proficiencies but

provides clarity and a more logical split between theoretical and practical skills.

Orthoptists

Sale and supply of drugs

5.70   In 2016, the HCPC published standards for the use by orthoptists of exemptions to sell and supply medicines. This set out the standards which registrants need to meet if they acquired the Medical Exemptions ("ME") annotation.

5.71   Since the development of these standards, accredited undergraduate courses have implemented these standards into their curricula. This now means that all graduates of accredited orthoptics programmes can expect to receive an ME annotation at the point they join the register (rather than undertaking post qualification training as was previously the case).

5.72   With this in mind, following consultation we have included within the profession specific Standards of Proficiency for orthoptists a range of new standards which cover the sale and administration of drugs currently contained in the standalone standards for sale and supply for that profession.

Paramedics

Pre-hospital care and out-of-hospital care

5.73   The current standards for paramedics make reference to pre-hospital and out-of-hospital care to differentiate the settings within which paramedics could work.

5.74   We have decided to move away from language relating to pre-hospital and out-of-hospital care, as consultees felt this did not adequately represent the current role of the profession which operates across a much wider range of settings.

5.75   We have removed references to pre-hospital and out-of-hospital care and in many cases, we have replaced these phrases with "emergency and urgent care" and "primary and community care."

Major incident response

5.76   We have added a standard to reflect the role paramedics are expected to play in responding to major incidents, including public health emergencies.

5.77   This new standard includes the importance of effective communication as well as the role of the paramedic in maintaining business continuity.

5.78   This standard also mentions the expectation that paramedics will be able to establish and run a triage system. This is an essential skill of incident

response but is also a reflection of the importance of leadership and autonomous working which run through the proposed Standards of Proficiency.

Physiotherapists

Technology and digital skills

5.79   Aside from language and tone changes to bring the standards into line in terms of consistency with the rest of the standards of proficiency, several changes were made to reflect the important role of technology and digital skills. This includes standard 13.21 which relates to evaluating data about trends in population health to inform physiotherapy practice.

Practitioner psychologists

5.80   Aside from general changes to wording in line with the standards, we are not proposing significant further changes to the standards for practitioner psychologists

5.81   We have reached this decision after analysing the consultation responses and following specific engagement with the relevant professional bodies and education providers.

Prosthetists/ orthotists

5.82   Aside from general changes to wording in line with the standards, we are not proposing significant further changes to the standards for prosthetists and orthotists.

5.83   We have reached this decision after analysing the consultation responses and following specific engagement with the relevant professional bodies and education providers.

Radiographers

Administration of drugs including intravenous and oral contrast agents

5.84   As part of our consultation, we included a standard around the administration of drugs including intravenous and oral contrast agents. Following consultation and further engagement with education providers and the professional body, we have determined that the administration of these agents is not expected at threshold level. We have therefore redrafted standard 12.20 and this now reads "understand the mechanisms for the administration of drugs, including intravenous and oral contrast agents."

Standard imaging techniques and minimally invasive interventional procedures

5.85   The current standards require registrants to be able to perform the "full" range of standard imaging techniques. We have decided to replace the term "full range" with "broad range" as we believe this enables education providers to work with more flexibility while still ensuring that registrants enter the register with the skills they need to practice safely and effectively.

5.86   We have also decided to remove reference to "interventional procedures" as we have determined that this is not threshold following discussion with professional bodies and education providers.

Discussions around modalities

5.87   We engaged with the professional body for radiographers on how we could further separate the different modalities of radiographers, given the feedback we received in response to our consultation.

5.88   The Society of Radiographers had argued for splitting the two modalities into two separate professions each with their own separate standards of proficiency. They believed that this separation would add useful clarity for service users and for education providers.

5.89   Each of HCPC's 15 regulated professions are set out individually in statute. We determined that the most appropriate approach was to separate out more of those standards that were different between the two modalities, but not to create two new separate professions with separate standards. The approach we are taking is based on different modalities and this approach is commonly used across HCPC's professions. We believe that this supports appropriate clarity, provides for separation where this is warranted and consistency where this is appropriate. We will continue to keep this area under review as the radiography profession develops over time.

Speech and language therapists

Inclusive language

5.90   We have made minor changes to wording in the standards of proficiency for speech and language therapists. These changes aim to make the profession-specific standards more inclusive and reflective of the needs of service users. This includes specific mention of the importance of understanding the needs of service users whose home language is not English and to registrants understanding the need to modify assessment and interventions in line with the specific needs of their service user.

5.91   These changes are in addition to the equality, diversity and inclusion obligations that all registrants will have to meet as part of their generic standards.

Preamble and glossary

5.92   We have amended the preamble to the standards to provide greater clarity about how the HCPC uses the standards and how registrants will be expected to meet these. In particular, we have created new sections called 'How HCPC uses the standards', which outlines how we use the standards of proficiency in our education, registration, CPD and FTP processes, and 'How to use the standards'. We have also clarified what we mean by threshold standards and how registrants will continue to meet the standards over time as their scope of practice develops.

5.93   In response to comments about our use of language in the standards, we have also created a section called 'Terminology in the standards' which acknowledges that not all terminology used will be preferred by all professions and that the standards are threshold so only reflect the minimum level of skills and knowledge for our professions to join the Register.

5.94   In the glossary, we have removed certain terms which do not feature in the standards of proficiency, and which had been carried across in our proposed Standards of Proficiency from the Standards of Conduct, Performance and Ethics glossary.

5.95   We have also revised certain definitions, based on stakeholder feedback, as well as introduced new definitions such as Quality Management, Safeguarding and Supervision.

Equality and diversity impacts

5.96   We hope to see positive impacts through our revised approach to EDI in the standards, which places greater emphasis on the need for registrants to practise in a non-discriminatory and inclusive manner and be aware of the impact of culture, equality and diversity on practice.

5.97   We have completed a detailed Equality Impact Assessment (EIA) (annexure C). This document reflects on the potential EDI impacts respondents shared with us during the consultation.

5.98   The EIA sets out many of the positive impacts on of the changes we are proposing to the SOPs and has been taken into account when we making our decisions. It also attempts to anticipate any unintended negative consequences for people with protected characteristics and sets out possible steps to avoid or mitigate this impact.

Implementation

5.99 The standards of proficiency are vital to the work of the HCPC and changes to them will have an impact across the organisation. The detailed implementation of these changes will fall to different departments according to their needs. Below is a summary of key dates in the implementation of the standards.

5.100 In January 2022, we held two workshops with a range of education providers to provide the basic information of our implementation plan and to receive input from them about its practicality.

5.101 Following Council approval, we plan to publish the standards in April 2022

5.102 Beginning in May 2022 (the last 5 months of the 2021/2022 academic year) we propose to enter a phased process of implementation. Following consultation with education providers, we are confident that it would not be feasible to expect implementation of the new SOPs in the academic year which begins immediately after their finalisation. Therefore, the remainder of academic year 1 will be used to allow education providers to develop plans for the implementation of the SOPs.

5.103 From May 2022, we propose continue to engage with stakeholders to ensure that key messages about the updates to the standards reach registrants in a variety of ways. From this time, the Professional Practise and Insight Directorate, along with Registration and Fitness to Practice will undertake targeted information campaigns, including webinars on the standards aimed at registrants.

5.104 From the 1st of September (the beginning of academic year 2) we propose to start using the new SOPs for approval processes of education programmes.

5.105 For existing programmes, we would expect the submission of their revised programmes to start from Autumn 2022 onwards, working with providers to establish a reasonable deadline date. We understand that programmes will need to make different levels of adjustments to meet the standards and will adopt a flexible and collaborative approach. By September 2023 providers will be delivering against the revised SOPs for all students in their approved programmes (i.e., not those who begin their course in September 2023 only).

5.106 We propose that the standards will come into effect on September 1st, 2023. This is the point at which registrants will need to meet the standards insofar as they are relevant to their scope of practice. It is also the date the standards will be applicable for the assessment of international applications. After this effective date, the practise of registrants will be assessed against these standards in FTP processes.

5.107 We will also be developing supporting guidance for key areas of the standards, similar to the Standards for Education and Training, over the coming year. This will support registrants to apply the standards in practice.

List of respondents

Below is a list of all the organisations that responded to the consultation.

Academy for Healthcare Science

Anglia Ruskin University - Paramedic Science

Association of Educational Psychologists

British & Irish Orthoptic Society

British Academy of Audiology

British and Irish Orthoptic Society

British Association for Music Therapy

British Association of Art Therapists

British Association of Prosthetists and Orthotists

British Dietetic Association

British Nuclear Medicine Society

British Psychological Society

British Psychological Society

British Society of Hearing Aid Audiologists

Cardiff University

Chartered Society of Physiotherapy

Chatter Bug Speech & Language Therapy

College of Operating Department Practitioners

College of Paramedics

College of Podiatry

Council of Deans of Health

Derbyshire Healthcare NHS Foundation Trust

Dow University, Institute of physical medicine and Rehabilitation

Federation of Clinical Scientists (FCS)

General Medical Council

Glasgow Caledonian University

GMB Union

Greater Glasgow and Clyde NHS Board (Area Psychology Committee)

Health Education England

HEIW

Humber NHS Trust

Hywel Dda University Health Board

Institute of Biomedical Science

Institute of Biomedical Science

Kaleidoscope Children & Young People's Services (Lewisham & Greenwich NHS Trust)

Leicestershire Partnership Trust (Speech & Language Therapy Unit)

Lisa's neat feet

Liverpool John Moores University

London South Bank University (Occupational Therapy Programme)

National Community Hearing Association

NHS Education for Scotland

NHS Education Scotland

NHS Employers

NHS England & Improvement (Imaging Transformation Programme)

NHS England and NHS Improvement

North West Anglia NHS Foundation Trust

Oxford Brookes University

Patient, Carer and Public Involvement Programme (University of Sunderland)

Primary Care Dietetic team in Leicestershire Partnership Trust

Professional Standards Association

Psychologists for Social Change

Psychologists for Social Change and Ethnic Minority Educational Psychology (BEEP) Network

Public Health England

Queen Margaret University, Edinburgh (Audiology Team)

Registration Council of Clinical Physiologists

Royal College of Occupational Health Therapists

Royal College of Speech & Language Therapists

Society and College of Radiographers

South Warwickshire Foundation trust

Southport and Ormskirk hospitals

Staffordshire University Professional Doctorate of Health Psychology Team

The Christie School of Oncology

The Institute of Chiropodists and Podiatrists

The Walton Centre

UKABIF

UNISON

UNITE

University Hospital Coventry and Warwickshire

University of Cumbria

University of Leeds

University of Portsmouth (Operating Department Practice)

University of St Mark & St John

University of Sunderland (Patient, Carer and Public Involvement Group)