Council of Deans of Health

The voice of UK university faculties for nursing, midwifery and the allied health professions

Health and Care Professions Council - Consultation on the standards of proficiency for all professions on the HCPC Register

Council of Deans of Health written submission – October 2020

The Council of Deans of Health is grateful for the opportunity to contribute to this important consultation. The Council represents the 89 UK university faculties engaged in education and research for nursing, midwifery and the allied health professions.

The Council is responding to the generic standards of proficiency and profession-specific standards of proficiency for the following professions: arts therapies, dietetics, occupational therapy, operating department practice, orthoptics, paramedic science, physiotherapy, podiatry, prosthetics and orthotics, (diagnostic and therapeutic) radiography, and speech and language therapy.

Key messages

1. Healthcare profession regulation should be outcome-focused and risk-based.

2. Healthcare higher education is regulated by both healthcare profession regulators and higher education regulators. There is a need to ensure that regulation is not duplicative, but also that regulatory gaps do not occur if regulators were to simultaneously retreat from regulating necessary education and training functions.

3. Regulators should work collaboratively with education providers to enable flexibility and innovation in education and training, which enables student choice, enhances career pathways, allows individuals to meet the requirements of professional registration and upholds patient safety.

4. The HCPC's standards of proficiency should reflect the active role of professionals on the register. A shift in the language of these standards is needed throughout so that it reflects that registrants not only need to understand how to undertake certain actions, but also need to undertake those actions when necessary.

5. Equality, inclusion, and diversity must be central to these new standards. This includes ensuring that registrants acquire cultural competency and are aware of the impact of unconscious bias at the point of registration.

6. A more dynamic understanding of digital literacy and innovation within service delivery should be embedded in these standards to ensure they are fit for purpose. This is also the case for communication and engagement with patients and service users.

7. A new generic standard is needed across all professions on preparedness to support education and training in practice to grow placement capacity. Whilst newly qualified staff should not be expected to immediately lead education in practice, they should be capable of supporting the next generation of professionals in acquiring the skills to gain professional registration.

8. New generic standards on a more developed understanding of leadership and on the principles of delegation should be included in these standards.

9. Additional generic standards are needed which focus on the development of research skills and the role of registrants as consumers and producers of evidence and research.

10. The HCPC should consider if changes to the standards of proficiency necessitate changes to other standards, including the standards of education and training and standards of conduct, performance and ethics.

HCPC questions on the generic standards

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?

Standards 5 & 6 address these issues most closely.

Standard 5. Be aware of the impact of culture, equality, and diversity on practice

The Council is fully supportive of this standard and the need to ensure that at the point of registration newly qualified professionals have the knowledge, skills, and behaviours to provide care and treatment to patients and service users irrespective of background.

These standards on culture, equality, and diversity are critically important and therefore require a shift in language to ensure that registrants act appropriately. For example, standard 5.1 should state 'adapt practice to respond appropriately to the needs of all different groups and individuals' rather than 'understand the need to adapt practice to respond appropriately to the needs of all different groups and individuals'. This better reflects that it is the responsibility of an individual registrant to continuously act in this way rather than just understand that they should.

Cultural competency must be at the heart of these new standards as well as knowledge of the impact of different illnesses and diseases on different communities. This could be emphasised more in the standards. We recommend that standard 5.2/5A is amended from 'be aware of the impact of their own

values and beliefs on practice' to 'be aware of their own values and beliefs and how they could impact practice'. This would better recognise the need for professionals to reflect on their own values and beliefs and how they should work to counter them if they are problematic. This standard could be strengthened with reference to the effects of unconscious bias.

Some members indicated that standard 5B should include reference to those who are not digitally literate, considering the digitally enhanced nature of healthcare over the coming decade. Members in Wales indicated that these standards should speak to the importance of the Welsh language for education and service in Wales.

Standard 6. be able to practise in a non-discriminatory and inclusive manner

The Council is strongly supportive of the need for standards in this area. However, we believe that standard 6 should be strengthened from 'be able to practise in a non-discriminatory and inclusive manner' to 'practise in a non-discriminatory and inclusive manner'. Again, the active role of the registrant should be reflected in the language here and throughout these standards. These standards should also include reference to inclusion health and the needs of vulnerable and hard to reach populations.

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

This competency is outlined in standard 8A in the generic standards of proficiency. Standards on this competency also occur in the profession-specific standards. However, standard 2.3 should continue to include the word 'central' to ensure the key role of service users in decision making is retained.

More is needed in these standards about the importance of professionals advocating on behalf of their patients and service users. This includes children, particularly in early years, older individuals, and vulnerable individuals who cannot be directly involved in decisions.

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

Standard 3 addresses fitness to practise. The Council welcomes the inclusion of both physical and mental health in standard 3.2. Some members indicated that the HCPC needs to explain how registrants would be able to demonstrate maintenance of their own mental and physical health.

Standard 3A refers to 'coping strategies'. This needs to be clarified so it is clear that this is about registrants' own coping mechanisms. This wording may also have negative connotations for some professionals, who may need more substantial interventions to maintain their wellbeing than coping strategies. Some members indicated that 'resilience strategies' may be better wording. However, others stated that this may have similar negative connotations.

This standard should therefore be amended to include more generic wording such as 'wellbeing practices' and/or 'positive and preventative strategies'. There is a need to reference the importance of undertaking actions to prevent ill-health. Some members indicated that the HCPC should consider merging standards 3.2 and 3A given the similar nature of these competencies.

Paramedic registrants reflected that their profession-specific standard 3.4 may contain better wording than in standard 3A. This standard 3.4 states that paramedics should 'be able to develop and adopt clear strategies for physical and psychological self-care and critical self awareness, to maintain a high standard of professional effectiveness and a safe working environment'. This standard could potentially replace generic standard 3A across all professions. Similar views were held by operating department practitioners, regarding their profession-specific standard 8.9, which states that registrants should 'be able to identify anxiety and stress in service users, patients, carers [sic] yourself and others and recognise the potential impact upon communication.' Variants of both these standards are an alternative way to address issues with the current wording in the draft proposals.

Standard 3.3 refers to 'continuous professional development.' Different professions had different views on whether this should be 'continuous' or 'continuing.' The Council notes that the HCPC has standards of continuing professional development and that therefore the word 'continuing' should be used. We recommend that the HCPC hyperlinks its standards of continuing professional development to this section of the standards of proficiency in the final online version. This standard should also be updated to recognise the need to reflect and act on newly acquired knowledge across a registrant's career.

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

No. A more dynamic understanding of digital literacy and innovation, service delivery, and communication and engagement with patients and service users should be embedded in these standards to be fit for purpose for contemporary and future practice. The Covid-19 pandemic has revolutionised healthcare in the UK, with healthcare professionals 'treating half of patients in outpatients and primary care online.'[1] The digital skills in these standards must be set at the right threshold level needed to work in healthcare now and in the future, particularly in light of technological change over the coming decade.

This is important in relation to standards on confidentiality and how confidentiality and information governance must also be ensured on digital platforms (Standard 7). It is also critical to communication standards (Standard 8) and how registrants should moderate their verbal and non-verbal communication skills when delivering care to patients and service users digitally. Enhanced digital literacy is also necessary for standards on maintaining records appropriately (Standard 10).

This consultation also provides an opportunity for the addition of standards of proficiency around understanding AI, robotics, and genomics and how they may impact practice in the future.

[1] https://www.gov.uk/government/speeches/the-future-of-healthcare

Please also see our responses to standards 7, 8 & 10 below.

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

Leadership is referred to in standard 9A. However, we recommend that it is better situated in standard 4, which is focused on autonomous professional practice. There should be a standard about different styles of leadership and the need to moderate styles in relation to individuals and events. A standard on understanding the principles of delegation, especially in relation to the role of support workers, should also be included across all professions.

CoDH wider comments on the generic standards of proficiency

The Council has commented more widely on the generic standards of proficiency below.

Standard 1. Be able to practice safely and effectively within their scope of practice

The Council welcomes the rewording of both standards 1.1 & 1.2.

Standard 2. Be able to practise within the legal and ethical boundaries of their profession

Standard 2.1 refers to understanding 'the need to promote and protect the service user's interests at all times'. Some professionals deliver end of life care and in these circumstances the phrase 'promote and protect the service user's interests' must be understood in this context.

The Council is supportive of emphasising the importance of safeguarding patients and service users in new standard 2A. This standard could be strengthened if it is reworded to 'understand the importance of safeguarding and engage in appropriate safeguarding processes where necessary'. A shift in the 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 HCPC's standards should reflect the active role of professionals on its register. This standard should also reference the role of informed consent in this process.

Standard 2.5 should refer to 'informed and valid consent.'

Standard 2.7 now includes the word 'understand' rather than 'know about.' We welcome this amendment, which indicates that registrants will need to acquire a deeper and more contemporaneous knowledge of relevant legislation.

Standard 3. Be able to maintain fitness to practise

The Council's response to this proposed standard is outlined in question 3 above.

Standard 4. Be able to practise as an autonomous professional, exercising their own professional judgement

Standard 4.2 should be reworded to state 'knowledge, skills, experience, and the best evidence available to them at the time ….' It should also include reference to using knowledge, skills, experience and evidence to undertake assessments and make clinical judgements.

Standard 4.4 should be more expansive and include reference to a registrant's ability to not only be able to make and receive appropriate referrals, but also oversee and triage care where relevant.

Standards 4.5 & 4A are duplicative regarding problem solving.

Standard 4B should include reference to 'evidence-based practice'.

The Council welcomes the use of the word 'active' in the final standard in this section. However, this standard should be reworded to state 'be able to participate in training, supervision and mentoring.' The role of allied healthcare professionals in supporting students should also be included here.

Standard 5. Be aware of the impact of culture, equality, and diversity on practice

The Council's response to this proposed standard is outlined in question 1 above.

Standard 6. Be able to practise in a non-discriminatory and inclusive manner

The Council's response to this proposed standard is outlined in question 1 above.

Standard 7. Understand the importance of and be able to maintain confidentiality

We recommend that standard 7 is amended to include reference to information governance and the importance of confidentiality across digital platforms. More generally, these standards provide an opportunity for the HCPC to deploy a more dynamic understanding of digital literacy and engagement to ensure that these standards are fit for purpose.

Standard 7.1 should be amended from being 'aware of the limits of the concept of confidentiality' to 'adhere to the professional duty of confidentiality and understand when disclosure may be required'. Reference is needed to the principles of disclosure.

Standard 7.2 refers to 'information governance'. We recommend that it should refer to 'information and data governance.' This standard also refers to 'other relevant information', but clarity is needed here on what this means. Instead it may be better to refer to 'personal or sensitive data'.

Standard 7.3 should read 'to share information to safeguard service users and/or the wider public' instead of 'to share information to safeguard service users or the wider public'. Registrants should also be expected to share information in a timely manner.

Standard 7.4 of the speech and language therapy standards states that registrants should 'be aware that the concepts of confidentiality and informed consent extend to illustrative records such as photography, video and audio recordings.' This standard could be added to the generic standards.

Standard 8. Be able to communicate effectively

Standard 8.1 should refer to the need to potentially moderate verbal and non-verbal communications when using digital technology to communicate with patients and service users. It should also retain the reference to a 'diverse range of individuals, groups and communities.'

We welcome that standard 8.2 refers not only to the International English Language Testing System (IELTS) but also to the 'standard equivalent', as this is not the only test to assess English language competency.

Standards 8A, 8B and 8C should be re-ordered so that 8C becomes 8A, and 8A becomes 8C. 8B should remain 8B. This would better reflect the sequential importance of these standards.

The current 8A should refer to 'service users and/or their carers' rather than 'service users and their carers'.

Standard 8B should be amended to state 'reduce any barriers to communication where possible' rather than 'remove any barriers to communication where possible'.

The current standard 8C should include reference to 'digital technologies' to reflect the contemporary realities of practice.

Standard 9. Be able to work appropriately with others

Team working is vitally important. This standard should include reference to understanding the commonalities among professions. It should also recognise the uniqueness of different professions and the importance of understanding the extent of an individual's scope of practice and professional responsibility. There is also a need for a standard on understanding the principles of delegation, especially in relation to the role of support workers. A further standard on the importance of using inclusive language should be included here. Collectively, this would help to mitigate against confusion over roles, responsibilities, and capabilities.

Standard 9.6 of the speech and language therapy standards includes reference to registrants needing to work with 'educational professionals.' A standard is needed across all professions on preparedness to support education and training in practice in order to enable placement capacity growth.

Standard 10. Be able to maintain records appropriately

This standard should be reworded to 'maintain records appropriately'. There needs to be reference in this standard to digital information governance, digital literacy and maintaining digital records.

Standard 11. Be able to reflect on and review practice

Standard 11.1 should state that registrants do not only need to 'understand the value of reflection on practice and the need to record the outcome of such reflection' but also that registrants should act on reflective practice where necessary.

Standard 11.2 should not single out case conferences as a method of review. Several methods of review are deployed across the allied health professions. The standard should keep the reference to 'multi-disciplinary team review' and include reference to 'participation in clinical supervision.'

Standard 12. Be able to assure the quality of their practice

Standard 12.1 should include reference to being able to engage in 'current evidence-based practice'.

Standard 12.2 should be amended to include reference to gathering and using outcome measurements. This standard could also be merged with standard 12.6.

Standard 12.3 should retain its reference to evaluating outcomes.

In standard 12A we welcome the use of the more active 'to be able to' rather than 'be aware of'. This standard should be reworded to remove reference to 'audit procedures', which is outdated language. The references to quality management and quality assurance are more contemporary. The phrase 'clinical governance' could also be added here.

Standard 12A and 12.7 could be merged as they cover similar competencies.

Standard 13. Understand the key concepts of the knowledge base relevant to their profession

Standard 13.2 should be amended to refer to 'intervention efficacy' rather than 'treatment efficacy.'

Health promotion and disease prevention should also be referenced in standard 13.

Standard 14. Be able to draw on appropriate knowledge and skills to inform practice

Standard 14.1 should refer to registrants being aware of and responding to new evidence.

Standard 14.6 should continue to refer to interventions, as well as treatments.

Standard 14.8 should be reworded to state that registrants are not only aware of but should also engage with research methodologies.

Standard 15. Understand the need to establish and maintain a safe practice environment

Standard 15.2 should include reference to health and safety legislation and systems.

Standard 15.5 should ensure that registrants regularly assess the impact of practice environments on managing risk.

Questions on the profession-specific standards

3. 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
   c. whether we should include any additional standards

The Council has responded to the profession-specific standards of proficiency below.

Arts therapies

Standard 5.2 should be amended so that registrants are required to take account of 'psychological, social, cultural, economic and other factors' rather than just 'understand the need to' do this. It should refer to 'other relevant factors' and not 'other factors.'

Engagement with arts therapies educators indicated that they would support a profession-specific standard on the need for the 'cultural humility' of professionals.

Standard 7.4 should be amended to refer to '… and other arts-based work.'

Standard 8.9 should be amended to read 'be able to explain the nature, purpose and techniques of therapy to service users and carers and proceed within an ethos of co-designing the therapeutic alliance.'

Standard 9.5 states that registrants should 'recognise the role of arts therapists and the contribution they can make to health and social care'. This should be reworded to state '… and their integration with health and social care.'[2]

Standard 13.15 should remove references to 'normal and abnormal' and 'disorders.' The reference to 'mental illness, psychiatric assessment and treatment' should be reworded to refer instead to a 'continuum of mental health, clinical assessment and treatment and self-help and social resources'. The reference to 'congenital and acquired disability' should be reworded to 'disability/impairment and ways in which people experience themselves as being disabled.'

[2] This is standard 9.5 in the table of proposed changes for arts therapies, but standard 9.6 in the revised standards of proficiency for arts therapists. All responses refer to standards in the tables of proposed changes for individual professions.

Standard 13.17 includes a list of other disciplines. This should be reworded and condensed to refer to 'relevant aspects of connected disciplines.'

Standard 13.33 should include a reference to 'continuing to develop this through engagement in their own arts-based process.'

Standard 13.34 should also refer to competency with 'digital technology'. The word 'keyboard' is unnecessary.

Standard 14.11 should refer to a 'clear timescale and end' for therapy. If this was added in standard 14.11, the reference to timescales in standard 14.14 is not needed.

Standards 14.18 and 14.20 should be amended so that the word 'help' is replaced by the word 'support'.

Standard 14.20 should retain the reference to music technology.

Dietetics

Standard 2.9 should read 'understand the ethical and legal implications of withholding and withdrawing feeding including nutrition support.'

Standard 5.2 should refer to dietary and non-dietary factors.

Standard 9.6 refers to 'developments', but it should be clarified what this means. Reference to evidence-based interventions and their outcomes should be included here.

Standard 13.8 should clarify that this refers to clinical skills.

Standard 13.9 should clarify that this refers to food management skills.

Standard 13.13 should clarify that this refers to public policy.

Standard 14.10 now includes reference to diagnosis, which we welcome.

Occupational Therapy

Standard 12.7 of the published draft standards refers to the wrong profession – radiography rather than occupational therapy.

Standard 13A should be reordered and be the first profession-specific standard for occupational therapy in this section. The reference in this standard to 'relevant behavioural sciences' is vague and would benefit from greater clarity.

Standard 13B refers to understanding 'the concept of, and be able to support others with, the facilitation of learning.' This standard could be mainstreamed across all professions.

Standard 14.7 should be reworded to 'be able to conduct appropriate assessment or monitoring procedures, treatment, therapy or other actions safely and effectively.'

Standards 14.14, 14.15, and 14.16 could be merged as they are partially duplicative. However, any new standard referring to the content in standard 14.16 should refer to registrants gathering more information than just the functional abilities of service users. Occupational performance and participation are also key.

Operating department practice

The review of the standards of proficiency provides an opportunity to reflect on the Standards of Education and Training (SETs) for operating department practice. The Council believes that this should be an Bachelor degree-level profession.

Standard 11A states that registrants should 'be able to participate in team debriefings following treatment, procedures or interventions.' This standard should be added to the generic standards.

Standard 13.15 should refer to registrants being able to participate in the management of clinical emergencies.

Standard 14C should refer to more than just the 'initial management' of service users undergoing cardiac arrest.

Orthoptics

Standard 4D states that registrants should 'be able to coordinate a complete service user pathway, where appropriate, and in line with local guidelines.' This should be reordered to come just after standard 4.3, due to its importance.

Standard 14.15 states that registrants should 'understand the principles and application of orthoptic and ophthalmological equipment used during the investigative process.' This standard should be moved higher up in the order of standards in this section to underscore its importance.

Standard 15.16 refers to immobilisation. This should not be the final standard in the document as it may be read to suggest that this is the final intervention orthoptists undertake on service users.

Paramedics

Standard 8D should read 'be able to identify anxiety and stress in service users, carers, yourself, and others and recognise the potential impact upon communication.'

Standard 13.3 could refer to a more integrated role for paramedics working with other professionals in health and social care.

Standard 13.8 refers to pre-hospital and out-of-hospital care. This is too narrow, and it would be better to refer to emergency and urgent care and primary and community care.

Standard 14.16 should refer to safety netting and decision making. This standard is also potentially duplicative of standard 14.6.

Standard 14.20 should refer to more than just the functional abilities of service users. There should also be reference here to how this affects the management of patients and patient pathways.

Standard 15.7 refers to 'sterile fields.' This is quite specific and can be removed as it is inherent in standard 15.5.

Physiotherapy

Standard 13 refers to the key concepts of the knowledge base relevant to the physiotherapy profession. These standards need to ensure that they fully encompass the contemporary knowledge base and role of physiotherapists. The terminology may not be up to date and based too much on the bio-social-psychosocial model. It may be better to reframe these standards considering a more integrated and holistic model taking into account human systems.

Standard 13A should be amended from 'understand the structure and function of health and social care services in the UK' to 'understand the structure and function of health and care systems and services in the UK'. Where this standard is in the profession-specific standards of other professions, the wording should also be similarly amended.

Standard 13.6 refers to 'neuromuscular'. This should be changed to 'neurological.'

Standard 13.9 should include reference to health promotion.

Standard 14.2 should include reference to health informatics.

Standards 14.5 and 14.15 should be merged as they outline similar competencies around assessments.

Standard 14.6 refers to being 'able to form a diagnosis on the basis of physiotherapy assessment.' This should be amended to refer to a 'working diagnosis'.

Standard 14 should make more explicit reference to the ability of registrants to supervise physiotherapy students.

Podiatry

These standards offer an opportunity for the HCPC to provide clarity on the future use of the title: chiropodist.

Standard 13.6 should include reference to registrants being able to undertake assessments.

Standard 13.7 deploys a biological model. However, a more holistic approach may be needed. Reference to psychology should also be included here. This standard refers to 'foot health promotion and education.' This should be amended to 'foot health promotion, education and support.' This standard also refers to podiatric pathology. It would be better to refer to 'local pathology'.

Standard 14.18 should be reworded to refer to 'suitable or relevant debridement'. This will enable this standard to take into account sharp and other debridement as well as mechanical debridement. There should also be reference in this standard to managing dermatological disorders as well as nail disorders.

Standard 14.19 is covered by other relevant standards and should be removed.

Standard 15.6 should be reworded to state 'to be able to' rather than to 'understand.'

Prosthetics and Orthotics

Standard 12.8 should be amended to include reference to prescribing treatment plans of any device, the biomechanics of gait and interventions, and fit aspect and review.

Standard 13.10 should be amended to include reference to understanding the biomechanics of gait and interventions. It should also be amended to delete from 'in a manner which….' This clause is inherent in the rest of the standard.

Standard 13A states that registrants should 'be aware of the promotion of public health'. This should be reworded so that it states registrants should promote public health.

Standard 14.6 should include reference to making appropriate referrals.

Standard 14.11 refers to positioning, immobilising and moving service users. Reference should be made here to being aware of moving and handling legislation. It is also partially duplicated in standard 15.6 and the two standards should be merged.

Radiography

Standards 8.9 and 8D could be merged to create a standard that better matches the holistic approach that radiographers deliver in practice.

Standard 13.5 should be reworded to state 'be aware of the philosophy underpinning the development of the profession of radiography to inform understanding of current practice.'

Standard 13.8 should include reference to patient judgement. Risks are also likely to be different for diagnostic and therapeutic radiographers and this should be mentioned here.

Standard 13.9, which refers to quality assurance processes, should be included in standard 12.

Standards 14A and 14B are in the wrong order.

Standard 14.19 is inherent in standard 14.18. Standard 14.19 should therefore be removed or alternatively merged with standard 14.18.

Standard 14.22 is repetitive of standard 13.8. They should be merged.

Standard 14C repeats the word 'environments' and it should be amended to delete from 'or environments.'

Standard 14F should include reference to limiting exposure from radiation.

Speech and Language Therapy

Standard 5.2 states that registrants should 'recognise the possible contribution of social, psychological and medical factors to service users' communication difficulties and swallowing status'. The reference to social, psychological and medical factors should be added to standard 2.8. Moreover, standard 5.2 should be moved to sit within standard 8, which is focused on communication. It is important to note that not all individuals with communication difficulties have difficulty with swallowing and vice versa.

Standard 13.7 states that registrants should understand the 'relationship between language and literacy in relation to speech and language therapy'. However, this should be rephrased to refer to professionals having an understanding of sound awareness and school readiness skills.

In standard 13.10 the word 'normal' should be changed to 'typical.'

Standard 13.13 should refer to developmental disorders rather than developmental impairments.

Standard 14.18 states that registrants should 'be able to recognise the influence of situational contexts on communicative functioning and swallowing status.' This standard is unclear and needs to be clarified. Also, communicative functioning and swallowing status are not necessarily linked. This standard should therefore be split in two.

Standard 14.21 refers to 'developmental speech and language impairments.' This should be amended to 'developmental speech and language disorders.' The reference to 'fluency impairments' should be changed to 'dysfluency.' The reference to 'swallowing impairments' should be changed to 'dysphagia'. The reference to 'voice impairments' should be changed to 'voice disorders.'

Other questions

4. Do you have any comments on the proposed amendments to the preamble and glossary to the standards of proficiency?

No.

5. 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

Please see our answer to question 1 above.

6. 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?

Yes, with the caveats outlined in this document.

7. Do you have any additional comments about the standards of proficiency?

The Council of Deans of Health and the healthcare higher education sector is committed to working with the HCPC and others to ensure the effective implementation of these new standards of proficiency.

The HCPC should consider if these proposed changes to the standards of proficiency necessitate changes to other standards, including the standards of education and training and standards of conduct, performance and ethics.

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