Kite Flyers Convention Meets:[1] The BACP Reference Group, 22 June 2011

The accreditation of voluntary practitioner registers – presentation by Christine Braithwaite of CHRE/PSA[2]

Denis Postle

In my forthcoming book *Therapy Futures*, there are reports on several psychological therapies reference group meetings,[3] events invariably drenched in anxiety and even, eIpnosis felt, concealment. Transparency was probably a high value, but not everyone seemed to have brought any with them. Yesterday's gathering of stakeholders under the auspices of the BACP was different. Not only did anxiety seem absent but there was a palpable tone of optimism which, as the meeting went on, seemed grounded in honesty, openness and directness. More later as to the shadows which the bright light shining out from the speakers table might be casting.

Previous reference groups in these quite palatial premises of the British Psychological Society (BPS) in the heart of London's financial district had featured a circular setting that gave the illusion of levelling, with the vested interests facing each other across the table. This meeting was three to many; Lyne Gabriel, BACP chair, and Christine Braithwaite of the CHRE/PSA flanked by PowerPoint, and Sally Aldridge, BACP regulation chief, behind a table facing an audience in rows. As billed, it turned out to be well over an hour of presentation as to how, and even when ('July 2012, but it might slip to October'), the Professional Standards Authority (PSA) would implement quality assurance kite-marking of organisations that meet their criteria for holding a register of practitioners.

This was indeed a meeting of minds. Think of a power plug and a socket. The PSA will provide access to the 'National Grid' of Privy Council-derived State authority and thus the stakeholders present were being invited to consider voluntarily forming themselves into 'plugs' that will fit the PSA socket. Unlike most domestic supplies, this power circuit has a two-way function: cash in, kite-mark out. What a change from the Health Professions Council (HPC), who, to push the analogy a little further, not only attempted to electrify the whole field, but on the strength of the very frank testimony of the BPS chair at the meeting, left many psychologists struggling to recover from electrocution.

Without too much exaggeration, the content of the meeting took the form of Christine outlining, in a tranche of openly preliminary detail, how the PSA power socket was likely to be wired up, and how the relevant organisations could configure themselves so that when they were plugged in and PSA power was switched on, their registrants kite mark would light up.

Anyone familiar with the industrial process control[4] from which this PSA approach derives will know that quality assurance is a matter of specifying criteria and requiring the demonstration of outcomes – and so it proved here. Unlike the HPC which sought to impose a preordained structure that seemed to have been designed by someone previously employed by the prison service, here was the political in the shape of a person in front of us. In a *tour de force* of information and elucidation, Christine Braithwaite drew an increasingly rich picture of a possible therapy future. Retrospectively, eIpnosis realised that there was a delicate

balance being struck between the assembled organisations hearing an offer that they couldn't afford to refuse, and a simultaneous (financial) need on the part of the PSA for eligible organisations to access power through them. That this was a PSA pitch for business is not to demean the quality of what seemed to be on offer. Very promising.

Some headlines from the presentation: the CHRE/PSA is a small organisation,[5] less than twenty people, its foundation in 2003 arose directly from the Bristol Royal Infirmary scandal and, as Christine reminded us, was intended to redress the imbalance between the interests of (medical) professions and patients. It is financed by a statutory levy on the nine statutory regulators that it oversees. There will be some government funding to support voluntary registration scheme start-up costs. In respect of the psychological therapies, mapping research has been commissioned to discover who there is out here, and who would want, or could be attracted to, PSA kite-marking. The new approach is framed as 'right touch' regulation; note the echo of the coalition government's preference for 'light touch' regulation. It seeks to combine a proper evaluation of risk with proportionate assurance of quality in the organisations that plug in to it, and a helpful distinction was drawn between potential risk and the actual level. PSA quality assurance will be 'outcome focused'. To digress again for a moment, how astonishing and inexplicable that, from this perspective, the CHRE could have been so publicly congratulatory of the HPC, one of its supervisees.

As though the psycho-practice air in the room had become breathable, things could be said here that had previously been unimaginable, for example that 'a list is not a solution'. And that the PSA saw itself as 'needing to establish credibility' not only with those present but also 'in the consciousness of the employers and the public'. In the first use of a word that was to recur, the PSA had commissioned 'market' research to help with this process.

Moving on, the PSA will be in the business of accrediting registers, including, for example, cosmeticians and cosmetic surgeons who, we might divine, were currently an important focus for their 'right touch' remit. The PSA would be setting standards for the accreditation of organisations across the whole of health and social care; they would carry out impact assessments on the effects of regulation on employers and service users; they would map the characteristics of practice in each profession that offered organisations to be kite-marked; they would require evidence of 'good outcomes' from the applicant organisation – 'demonstrate to us how you do that'. Accreditation by the PSA will provide assurance to the public that a register achieves 'good outcomes'. The PSA, we were told, is not here to restrict the market.

In what seemed a notable statement, Christine said that 'the Authority would facilitate rather than direct or control the market'. There would be a PSA kite-mark, and the principle requirement for securing this endorsement would be: 'was an organisation "fit" to hold a register?'. This would be based on a PSA assessment of reputation and credibility, and whether the organisation delivers 'good outcomes'. This assessment would take a close look at systems

for management of the register; and standards for registrants across three domains: personal behaviour, technical competence and business practices. An essential ingredient of the PSA approach was that, for a person seeking a practitioner, an accredited register would 'add value'.

An organisation offering itself for assessment would be faced with:

- Meeting published criteria
- A readiness test
- An application and preliminary assessment
- A probationary period

After accreditation had been agreed there would be:

- Ongoing monitoring and periodic review

This was described as a 'systems' approach to regulation, and as an example we heard the third of five references to the PSA's engagement with the emergent cosmetics industry, cosmetic surgeons and Botox services

What seemed absent as an integral part of what we were hearing (as so often across the psy field) were service users. In response to an eIpnosis query suggesting a place on the PSA staff for people with experience as service users, Christine, missing the point, said that all the council members[6] were 'lay'. Yes, maybe, but actual service users appear to remain outside of the accreditation process, and how to include them remains an awkward problem that continues to define professionalisation and to undermine professional credibility.

A concern was raised that attracting only those large organisations that had the resources to adopt PSA accreditation might generate market distortion, and that diversity and choice would thus be undermined by standardisation. Christine responded that again, the issue was whether, for the service user, accreditation 'added value'.

There was some discussion of standards, of where to 'set the bar', and we heard that a feature of the PSA agenda was how funding would be handled, both in the interests of sustaining choice and diversity of supply, and to ensure that smaller organisations were not at a disadvantage. We were assured that the PSA business model was not-for-profit. There were twenty people already on the staff and an outline budget included two more, costed at around £200,000, presumably to look after accreditation of voluntary registers. In a later extension of this discussion, relations between the PSA and the organisations it accredited were described as 'business to business'.

There have been elephants in the room at previous reference group meetings, and this was no exception. Even though there appeared to be several people present who had previously been, or still were, HPC enthusiasts, no mention was made throughout of the actuality of the HPC's capacity for 'holding' competing voluntary registers. However, in an illuminating aside, Christine hinted that at a time when events were moving quickly,

government thinking about regulation favoured 'flexibility' – they saw statutory regulation as slow, expensive and difficult to change.

One last but possibly vital specific that emerged in a later group discussion: the PSA looks set to require what was described as a 'Chinese wall' between the person in a registrant organisation who is responsible for the register and the rest of the organisation, perhaps through some form of trustee status. If so, this is a considerable requirement, and it might tend to limit accreditation to those organisations that had the resources to sustain it.

This hopping about from topic to topic doesn't do justice to the coherence of the pitch/presentation that we were hearing, but it has seemed necessary in selecting for relevance here. The PSA website will feature documents that detail their specifications.

Is this PSA future an option that psychological organisations will welcome? How about, for example, the Independent Practitioners Network (IPN)? For practitioners devoted to professional values, the PSA seems undoubtedly a very promising, 'least-worst' outcome of the regulatory debacle. But if we were to pull back to look at this meeting's discourse from a wider political perspective, what might we see?

The presentation had led a conversation about quality assurance of supply (but leaving out demand) of service delivery in the psychological therapies market. Market research and mapping of the field would be carried out. While Christine claimed that the PSA was not attempting to control the market, this research and the PSA's standards setting could be thought to hide an adroit 'facipulation' of the market, as though setting standards for what constitutes a tomato didn't affect the market for tomatoes.

If this seems too glib, and it might prove to be, what seemed to eIpnosis more certain are three things. Firstly, that the PSA is en route to endorsing a valuation of the professions as custodians of the public interest, an assessment the Department of Health had not so long ago decisively rejected,[7] a moment of history that merits being remembered. It will be interesting to see whether the PSA criteria can fix the problem the DoH correctly identified as professional self-interest. Second, from a 'psyCommons'[8] point of view that sees the psychological professions as walled gardens of privileged expertise, PSA kite-marking gives the professions exactly what they have wanted: recognition, status and potential parity with the medico-scientific industrial establishment. Added to this, PSA endorsements will contribute a huge boost for the professionalisation that has taken human condition work from vocation to job/career. Third, what we were hearing, and being invited to join, appeared to be a branch of the NHS-style commissioning culture,[9] of the privatisation of servicing mental health needs in the NHS. Even though the presentation came from a public service source, it was phrased in terms of a culture of markets, business plans, business-to-business relations and a requirement for demonstrably good outcomes.[10] Happily, the intent was to engage a wide range of suppliers, but nonetheless, all would be obliged to meet the commissioning authority's taxonomy of criteria and standards.

Modern managerial styles tend to be expressed through hierarchical top-down control. Perhaps as one consequence of a decade or three of the migration into the corporate sphere of humanistic psychology (e.g. team-building and facilitation skills), post-modern

corporate management is now often about managing clusters, or teams of employees. They are encouraged to buy into, and are held together, by the shared ethos of the corporate culture, which – so long as it delivers a good 'bottom line', i.e. a 'good outcome' – attracts little top-down control. What we seemed to be hearing here was a version of this corporate style, an ethos that Rushkoff [11] describes as having taken over the world. Not only do we inhabit it, it inhabits us, and perhaps that's why, as *eIpnosis* felt, it was very attractive and strongly supportive of a 'buy decision'.

And yet, do we want to join it? Or in response to its seductive promise, do we, on behalf of the client experience, need to hold a counter-cultural, if marginal position? Time will tell, it's early days. But what the PSA has on offer is a therapy future that the field probably can't afford to refuse.

Endnotes and references

1. This is a slightly revised version of an article written by Denis Postle after attending a BACP reference group meeting at which Christine Braithwaite of the Council for Healthcare Regulatory Excellence (CHRE, soon to be 'The Professional Standards Authority', or PSA) outlined proposals for a new government-backed voluntary registration scheme. The piece first appeared on 24 June 2011 on eIpnosis (http://ipnosis.postle.net/), an on-line journal for the Independent Practitioners Network (IPN), and also forms Chapter 13 of Postle's new book *Therapy Futures: Obstacles and Opportunities*, to be published shortly by PCCS Books (www.pccs-books.co.uk).

2. PSA – the Professional Standards Authority – will not be active until the delayed Health and Social Care Bill 2011 is on the statute book.

3. *eIpnosis* reports on Psychological Therapies Reference group meetings:
The Psychological Therapies Reference Group meeting, 29 March 2007 (Chapter 16) (http://ipnosis.postle.net/pages/FromNo2Unless.htm)
The Psychological Therapies Reference Group meeting, 18 September 2007 (Chapter 18) (http://ipnosis.postle.net/pages/Sept1807RefGRPDogs.htm)
The Psychological Therapies Reference Group meeting, 18 September 2007 (Chapter 20) (http://ipnosis.postle.net/pages/Regulation.htm)
The Psychological Therapies Reference Group meeting, 10 June 2008 (Chapter 25) (http://ipnosis.postle.net/pages/June102008RefGrpReport.htm)

4. The PSA approach echoes for me the corporate systems approach (statistical process control) that the Ford Motor Company introduced in the 1980s as a way of upgrading the quality of their products. Ford negotiated and agreed specifications for what suppliers would henceforth deliver, and notified them that they would no longer be checking the quality of any of it. That is to say they devolved responsibility for the quality of their production on to suppliers. It too was an offer that the suppliers couldn't afford to refuse.

5. PSA web-site – http://www.chre.org.uk/

6. PSA council members and affiliations – http://www.chre.org.uk/council/83/

7. Department of Health critique of proposal for a Psychological Professions Council submitted by nine professional bodies (headline summary):
'The Government is unable to accept this proposal for the following broad reasons, which are expanded in detailed comments on each part of the proposal below. The proposal is judged to be:

- Flawed in its understanding of regulatory processes.
- Internally inconsistent.
- Flawed in not consistently promoting public safety.
- Based on largely unsubstantiated criticism of the Health Professions Council (HPC) system and a misunderstanding of the requirements of statutory regulation common to all regulated professions.' See http://ipnosis.postle.net/RTFDOCS/DoHcritiquePPC25-7-07.rtf

8. 'Psychological Commons' – see http://p2pfoundation.net/Psychological_Commons

9. Christine Braithwaite is a member of the Institute of Commission Management.

10. Manchester PCT Commissioning guidelines 2006: 'Improving health, wellbeing and life chances in Manchester'.
Commissioning has to be 'CLEVER';
Competent and intelligent
Legitimate – acting transparently on behalf of the public
Evidence-based
Value driven – consistent with public service
Enabling quality and innovation – driving this forward via contracts
Resourced – sufficient people skills and information
(http://www.docstoc.com/docs/82660017/2NHSPCTManchesterCommissioningStrategy)
See also NHS Commissioning guidelines: http://www.ic.nhs.uk/webfiles/commissioningcycle.pdf

11. Rushkoff, D. (2010) *Life Inc: How the World Became a Corporation and How to Take It Back: How We Traded Meaning for Markets, Society for Self-interest, and Citizenship for Customer Service,* London: Vintage Books

After two decades as a broadcast documentary film-maker, **Denis Postle** become a humanistic psychology practitioner offering personal and professional development, coaching, mentoring and supervision. A founder participant in the Independent Practitioners Network and also a photographer and musician, he edits and produces the eIpnosis website and has contributed extensively to the debate about state regulation