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Responses to our consultation on the Council election rules

health professions council

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Foreword

I am very pleased to present this summary of the responses we received to our proposals for the Council election rules.

We received a total of 23 written responses, offering constructive comments and feedback that were broadly centred around the four questions we asked in the consultation document. Respondents provided us with many useful ideas, suggestions, recommendations and comments that we will draw on as we make decisions.

During the course of the consultation, you raised a number of issues, including:

- electronic voting, where you agreed with us that we should be looking to move in this direction, but were concerned that we should deal effectively with the practical implications such as security, and that we should provide alternative arrangements for voters who could not use an electronic voting system;
- home country representation, where you expressed dissatisfaction that we have a legal obligation that requires us to intervene in elections. However, we received no lawful alternative suggestions to the scheme that we have proposed;
- the grouping of similarly-sized electorates, where you were generally content with the change that we have suggested, but asked us to provide reasons for our decision to change our approach.

You can learn more by visiting our website www.hpc-uk.org, where you will find the latest information about the consultation. We aim to publish more information about our elections in late 2004, after the Privy Council has approved the legal rules that underpin the process.

Thank you once again for your interest in our work.

Chair

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Introduction

We are a new regulator called the Health Professions Council and our job is to protect the health and wellbeing of people who use the services of the health professionals registered with us. We are run by a Council, which has 25 members including its President. Each of the 12 professions we currently regulate is represented by a council member (called registrant members), and there are 12 council members who are not health professionals as well (called lay members). In addition, there are 12 members (called alternate members) who attend Council and Committee meetings in the absence of the 12 registrant members.

As a regulator of health professionals, we are legally and morally obliged to make sure that all the health professionals we register have a voice in how we operate. One of the ways that we do this is to hold elections for the registrant and alternate members. The registrants in each profession elect a registrant and alternate member, thus ensuring that they have a say in the running of the Council.

When we were set up in 2002, we ran a major consultation on how we would operate. In that consultation, we asked a number of questions about the election scheme that we proposed using. We had many responses to our proposals for elections, and took a number of key decisions in the light of the consultation about how the scheme would work. These were that:

- candidates will be able to stand for election either as registrant members or alternate members but not both. This could lead to the development of joint tickets;
- the election scheme will be 'first past the post';
- we will ask the Electoral Reform Society (ERS) to run elections on our behalf;
- we will use a special method for dealing with the 'home country representation requirement' as set out in our proposals (the requirement says that there must be at least one registrant or alternate member from each of the four countries of the UK: England, Scotland, Wales and Northern Ireland. It is discussed in more detail later in this document);

We also decided that:

- each candidate for election must have at least six nominators from the same part of the Register (eg a candidate for the election of the physiotherapists' registrant member must be nominated by at least six physiotherapists);
- we will group professions together so that each year, the total electorate is roughly the same size when the three electorates voting are added together (the law says that only a quarter of our professions will vote in any one year);
- we will run the elections for registrant and alternate members of each profession at the same time, but they will be administered separately.

Since that date we have been developing our proposed election scheme in further detail, and in May 2004, we launched another consultation, seeking your views on three proposed election scheme rules. As this is the second consultation on the subject of our election scheme, we have chosen to make it six weeks long, rather than twelve. We must have rules in place in time for elections in July 2005.

In the consultation document, we asked respondents to provide comment and views on three different issues:

- whether to use electronic ballots;

- the mechanism for meeting the home country requirement. We asked respondents to suggest what steps, if any, the Council should take to reduce the likelihood of a conflict between its duties to hold free and fair elections and to ensure country representation among elected members;
- the decision to group similar sized professions together.

We sent out 60 copies of our consultation document, *Consultation on the Health Professions Council Election Rules*, to a range of stakeholders. These included bodies representing members of:

- currently regulated professions
- aspirant professions
- other professional bodies

as well as other organisations such as government departments. We also published the document on our website (www.hpc-uk.org). We asked you to send written responses by 5th July 2004. By this date, we had received 22 written responses from organisations and 1 response from an individual.

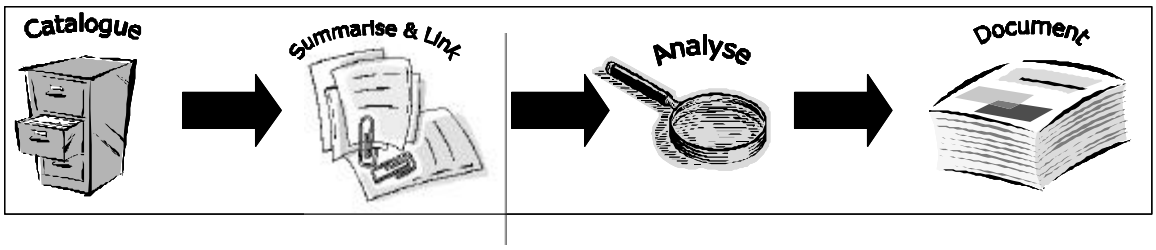
Analysis of respondents

Analysing the consultation

Now that the consultation has ended, we have analysed the responses we received and we present a summary of these along with the key decisions we have made in light of the feedback from the consultation.

To make sure our analysis of your comments was fair and transparent, we used a simple four-step process for working. The diagram below shows how it worked.

Procedure for working



The first step was to catalogue each written response to the consultation document. This was done whether the response was a letter, an email or a form. We catalogued each response with some additional detail, such as the date it was received, what organisation (if any) the respondent told us they belonged to, and whether the response was being sent on behalf of an organisation or in a personal capacity.

Next, we summarised each response, linking the comments being made to the themes of our consultation, to provide a clear structure for analysis.

Finally, once we had structured all the information, we went on to analyse it. In deciding what information to include in this summary, we looked at the volume of responses received on each topic, assessed the strength of feeling of the responses, and took into account the details of each individual response.

The proposals received a great deal of interest, particularly from organisations with a special interest in this work. We have listened very carefully to these comments and worked hard to take them into account when making our key decisions. The process we used means there is an audit trail linking the analysis back to the responses we received.

Summary of responses and key decisions

1. Electronic voting

Our proposals

We proposed including provision for electronic ballots in the Rules.

Your responses

The majority of respondents agreed with our proposal to introduce electronic voting. Respondents said that a modern regulator should provide electronic voting; that electronic voting could increase participation rates (which are historically low for regulators of health professionals); and that electronic voting could improve the relationship between registrants and the Council.

However, while approving in principle, respondents raised four key issues that they believed the Council would need to take into account.

The first of these was the need to ensure that the system is secure and protected against unauthorised access and in particular multiple voting. The Association of Clinical Scientists (ACS) said that "the voting system **must ensure the prevention of** rather than only **aim to eliminate** multiple voting and hacking [emphasis as per original response]". The Chartered Society of Physiotherapy recommended that the HPC "consult with any other organisation that may have used this system of voting, to be aware of any possible pitfalls" and that we run a pilot scheme "at this time".

The second was the need to ensure the scheme was cost effective and efficient.

The third was the need to ensure the scheme allows all registrants to participate, bearing in mind that some registrants will not have access to IT equipment; others will not have the necessary skills; and others may have a special need, such as a sight impairment. Respondents suggested that we make electronic voting an additional option for registrants, rather than the sole method.

The fourth issue was that the system must be user-friendly.

The College of Occupational Therapists was worried that "Rule 7 (3) [which says 'a poll may be conducted by means of a postal ballot or an electronic ballot'] implies that the Council may decide which option to pursue; this is in conflict with other parts of the paper and ambiguity needs to be resolved".

Key decisions

We will look to introduce an electronic voting system, taking into account the key issues raised by respondents. We believe that this is the way forward for us as a modern regulator, potentially leading to many benefits, including those listed in the original consultation and also:

- the count and declaration of votes could be completed much more quickly;
- the costs of running the election could be lower, as the distribution of postal votes is the biggest cost involved in a paper ballot.

However, we recognise that a complete replacement of the postal system with an electronic system so that voters cannot ask for individual postal ballots would be problematic. The Rules specifically provide for the Council to have the choice as to whether the default method of voting will be postal or electronic, but also for individual registrants to tell us if they cannot use the electronic system.

Where this is the case, we will send a paper ballot to that registrant instead. We believe that this is in line with the principles set out in *The implementation of electronic voting in the UK*[1], which says that that the implementation of e-voting should be based upon "the principles of flexibility and choice, ensuring that voters are not restricted to one preferred method but can chose the method of voting that most suits their lifestyles and preferences". We believe that, for voters to maintain confidence in the system, the traditional method of voting would have to be made available at present, although we acknowledge that this will be more costly than providing only a single option.

We will therefore run a pilot programme to develop electronic voting, to provide information and experience about security, costs, accessibility and user-friendliness. We will also hold discussions with other organisations, including both those who have used electronic voting, such as the General Medical Council (GMC), those who have expertise in this field, such as the ERS, and organisations who may be able to help with specific issues such as access, such as libraries. In 2003 the GMC held a general election to fill posts for elected members, proving members with the option of voting through the internet. 1,210 doctors voted on the internet and the GMC now plans to increase the use of electronic voting[2].

A final point: we believe it is important to recognise that it is impossible to provide absolute assurances about the security of any voting system, as for instance the ACS appear to be asking us to do. It is true that electronic votes risk being hacked—but ballot boxes may be stuffed and postal votes stolen as well. As with any secured system, the challenge for us will be to reduce the risk of wrongful interference to sufficiently low levels that participants and observers have confidence in the process. We take the security of our voting system extremely seriously and this will be reflected in the process we use to choose and to implement any e-voting process.

2. Home country representation

Our proposals

The law says that at least one registrant member or one alternate member has to be appointed from each of the countries of the United Kingdom (England, Scotland, Wales and Northern Ireland). It also says that these members must live or work, most or all of the time, in the country concerned. We call this the 'home country requirement' (HCR).

Unfortunately, we believe that the HCR is at odds with our obligation to ensure that elections are free and fair. This is because we will be required to overturn an election result if it would not result in the HCR being met (e.g., if the voters did not elect a registrant or alternate member from Northern Ireland). We are dissatisfied with the current law and are pressing to have it changed. The government has so far indicated that it is not prepared to change the law, so we must do our best to create a scheme that meets our obligations.

Therefore, we proposed the following scheme in our rules [Rules 11(2) to 11(4)] for when the HCR has not been met.

The fundamental elements of the scheme are as follows:

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[1] Pratchett, L. (May 2002). De Montfort University, University of Essex, BRMB International

[2] http://www.gmc-uk.org/council/2003-10/item_8_elections_review.doc

- we will appoint one of the unsuccessful candidates in place of one of the successful candidates, to make sure the HCR is met. We have called this person the *replacement candidate*;
- the replacement candidate will take the place of the successful candidate for the election in which they both stood. So, if the replacement candidate stood in the election for the position of alternate member for physiotherapy, they will replace the candidate who won the election to be alternate member for physiotherapy.

We will use two criteria to choose the pool of people who could be the replacement candidate:

- they must be from the unrepresented country;
- their appointment as replacement candidate must not leave another country unrepresented.

The pool can have people from any of the elections that have been held.

We will then determine which person in this pool had the highest *percentage differential vote.* This is the relative difference between the votes cast for them and the average vote for candidates standing in their election. If we were just to look at which unsuccessful candidate received the most votes, we would be ignoring the fact that some electorates are very large compared with others. If we were just to look at which unsuccessful candidate received the greatest fraction of votes as a fraction of the votes cast in their election, we would be ignoring the fact that some elections will have had stiffer competition (in the form of more candidates) than others. Using the percentage differential vote deals with both these issues.

We will appoint the person with the highest percentage differential vote to be the replacement candidate.

We need to try to be as equitable as possible between the different professions, despite their different sizes, in the event of our having to invoke these rules. This has led us to change our proposals for how we will group professions together, as explained in the next section.

We realise that this scheme is not easy to understand, although we have tried to describe it as clearly as possible. The complexity is a result of our trying to minimise the democratic deficit we believe is an inevitable result of our legal obligations.

Your responses

Many respondents stressed that there was a need for home country representation. This included the sole individual respondent who wrote to us, for whom this was the key point of concern. However, respondents were also deeply concerned about what they saw as the fundamentally unfair requirement being placed on the HPC to intervene in elections to meet the HCR. For instance, the Association of Operating Department Practitioners said "it is clearly undemocratic to deny a Council seat to a candidate who has fairly won an election and received a majority of votes from the profession[3]".

Some respondents, including the Chartered Society of Physiotherapy in Wales (CSP Wales) believed that the scheme we have proposed is unlawful because of the HCR. It is important to understand that this is not a choice for the HPC but an obligation forced on us by the drafting of the Health Professions Order 2001. As the Order mandates the HCR, we have no choice but to adopt a scheme that is compliant, although we are unhappy with the results. In putting these proposals together, we took advice to ensure that we comply with our legal obligations and we are satisfied that we do. That is why we have not, as the CSP suggested, made a

[3] Although it should be noted that, in a first-past-the-post (FPTP) election, the winner is the candidate with the most votes, and they need not have won the majority of the votes cast

provision for "a candidate to protest against the appointment of a candidate from the 'unrepresented home country'". As the CSP points out, candidates (and indeed others) would be free to challenge the validity of the election rules by way of judicial review.

Many respondents urged us to adopt solutions that would be unlawful as they would not comply with the Health Professions Order. This included the Association of Clinical Biochemists, who wished to see "an additional Council member elected for each home country", as did CSP Wales and the College of Occupational Therapists (COT); the Institute of Chiropodists and Podiatrists suggested "co-opting three persons, one from each of the other UK countries who do not win the ballot, as the representatives" or asking "ALL the professional bodies … to nominate suitable persons to fill the 'country' vacancies"; the Society and College of Radiographers suggested a rotating system of restricting elections for each profession in turn to candidates from a single home country. If we were to adopt any of these suggestions, we would be acting outside our powers: we would therefore be liable to challenge in the courts, and the decisions taken by any Council constituted on the basis of these suggestions would not stand.

Other respondents, including the Scottish Branch of the British and Irish Orthoptic Society (SBBIOS) complained that the scheme we have suggested may lead to one or more of the home countries only being represented by alternate members. The NIHPCLG also said that "the [Health Professions Order 2001] states that there has to be at least one registrant member from each of the 4 home countries on Council". In fact, the Order says "of the registrant and alternate members, at least one member shall be elected from each of the countries of the United Kingdom…". The law therefore says quite clearly that the HCR applies to the registrant and alternate members as a whole, and we are not at liberty to apply it to a sub-group. We note that, as we stated in the initial consultation, candidates could, if they wished, run on joint tickets for the registrant and alternate posts for their profession.

Many respondents said that the HCR meant that what we were proposing could no longer be described as FPTP. We believe that the scheme that we are implementing can best be described as a form of FPTP. However, we fully accept that, because we may be legally required to intervene in the election results to meet the HCR, there is a possibility that one or more council members will have been elected despite not having won the popular vote.

The CSP complained that we had not consulted on the use of alternatives to FPTP voting such as the single transferable vote. We did not do so because we had previously consulted on this issue in our consultation in 2002 and, in the light of that consultation, chosen to adopt FPTP. The CSP also complained that "it is not known if the HPC have consulted with any other regulatory bodies operating a similar election scheme (in order to meet the home country requirement)". To the best of our knowledge, no other regulator has the statutory requirements that we do. We are, of course, in a unique position in view of the large number of professions we regulate.

A comment that was representative of much of the response we received was made by the British Dietetic Association, who said "the Rules [that the HPC has proposed] are not ideal, however they are probably as good as anything else that is likely to be achieved, without changes to the [Health Professions] Order". This view was echoed by the Federation for Healthcare Science, who said that "the Federation believes the rules relating to home country representation are somewhat vague, difficult to understand and confusing but nevertheless cannot suggest a credible alternative".

We had a number of complaints that the rules regarding the HCR were difficult to understand, and a number of comments that implied a misunderstanding of how the rules will operate. For instance, the Association of Operating Department Practitioners (AODP) commented that "the HPC have not stated the criteria for selecting which of the 3 professions [the HCR] will be applied to"; in fact, the HCR scheme is based on working across all the elections taking

place at any one time. The AODP also asked how we "intend to apply the rule of one quarter of the Council being elected every year now there are 13 parts of the register?". In fact, the Health Professions Order sets out how council members must retire in Schedule 2 Paragraph 6(a); this has the knock-on effect of setting how the elections must work. For simplicity's sake, we have said that a quarter of the council seats will be up for election each year, but the full details are set out in the Order[4].

In similar vein, the SBBIOS stated that we "must make sure that the rules of election allow for a wide and inclusive representation of each profession". Of course, the law says that each profession is represented on our Council by a single registrant member (with a single alternate member for times when the registrant member is unavailable). Hence, it is impossible for us to guarantee that each profession has a representative from each home country or something similar.

Finally, the Northern Ireland HPC Liaison Group stated that "any of the three home countries candidates would be [unlikely to be] voted in on a first-past-the-post election". In fact, there are four home countries—England, Scotland, Wales and Northern Ireland. We also disagree with the contention that voting will definitely take place along geographic lines (e.g. Scottish voters voting only for Scottish candidates, etc); we recognise that this is a possibility, but we believe that voters will ultimately exercise their choice in favour of the candidate who, in the round, they believe will best represent their interests. While geography may well be a factor, there are other factors that will also be important, such as the reputation and manifesto of the candidate. In addition, it is important to note that the reason for having an HCR in the first place is to ensure minority representation on our Council. Each country is guaranteed a voice among the council members, although we accept that some respondents wanted a guarantee that countries would be represented by a registrant council member (see above). The NIHPCLG also stated that the scheme we have chosen does not adhere to the Nolan Principles which aim to ensure openness, honesty and transparency in public body business. We believe that we have been clear and honest about what we have been trying to achieve and the constraints implied by legislation. We also note that the Nolan Principles apply to individuals, not organisations—and indeed we require our council members to comply with them.

The AODP stated that our scheme "appears work only when the whole Council are elected in one go". We do not believe that this is the case, but we accept that the electing of a quarter of council members each year will lead to an increased use of the HCR scheme. This is because there is a less chance of fulfilling the HCR by election alone with only a quarter of the seats being contested. However, this is something that we have no powers to change.

The COT stated that the rules do not explain what will happen if "a nominee [has] to withdraw after the nomination day but before the election". If someone withdraws after nomination day, the ballot papers or ballot arrangements will already be in place with that candidate's name on them. We would have to decide what to do on a case-by-case basis.

We agree that the rules are difficult to follow; this is because they must be written in legally precise language and they are covering a difficult subject. We have tried to explain the rules in plain English in the previous section of this document and we hope that this makes the system clearer to follow.

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[4] Schedule 2 Paragraph 6 of the Health Professions Order 2001: "The Privy Council … shall ensure that (a) the terms of office of equal proportions of registrant and lay members, being one quarter or the nearest whole even number above one quarter) of the Council membership, expire at the end of one, two and three years respectively beginning with the day after the end of the second transitional period…"

Respondents suggested other ways in which we could reduce the likelihood of a conflict between our duties to hold free and fair elections and to meet the HCR. These included the British Association of Play Therapists (BAPT), who suggested that we encourage each profession to nominate at least one candidate from each home country. We are keen to see the widest possible range of candidates standing in elections for council membership and will certainly be promoting the benefits of standing across all four home countries. However, we want to be sure that we are not seen to be encouraging any particular individuals to stand, which would be seen as unwarranted interference in the democratic process, and we will have to be very careful to avoid this in any communications that we produce.

The BAPT also commented that "elected Council members should understand their remit to be to represent each [profession] in all four Home Countries…". This is correct, and indeed, our council members, whether elected or appointed, have the same duty to help us "to safeguard the health and well-being of persons using or needing the services of registrants[5]". Council members do not have a duty to represent the interests of their home country, although the Council has a whole has to take the interests of registrants in each home country into account in the way we work. This would also apply if we were to take steps to remedy the COT's complaint that "registrants are only being asked to vote on one mandate i.e. election of Council member and alternate, without understanding that a second requirement has to be met".

Key decisions

We will adopt the HCR scheme as set out in our rules. We will work to ensure that registrants are properly informed about how the elections work and we will, with the help of the Plain English Campaign, produce documents explaining how our elections work. The information will cover all aspects of the election, including the HCR.

We will continue to press the government for changes to this part of the Health Professions Order, and we will look to tie such changes in with any major changes to the structure of the register (which is the subject of a separate consultation).

3. Grouping of similar professions

Our proposals

As a result of the 2002 consultation the Council decided to group professions together such that each year the total electorate is roughly the same size (when the three electorates voting are added together). However, we have thought further about this approach and taken advice from the Electoral Reform Society (ERS). Consequently, we have taken the decision to group similar sized professions together.

The reason for the change relates to the HCR scheme and is quite complex. We put similar sized professions together is to minimise the relative degree of disenfranchisement that might occur across the professions involved if the HCR scheme was used. An example may make this more clear: suppose there were two possible professions involved in an election, and a substitution was required. Suppose also that one profession was much larger than the other (perhaps 40,000 potential voters as against 1000). If the successful candidate for the larger profession were replaced to meet the HCR, because the unsuccessful candidate with the highest differential percentage of votes was a member of that profession, then we would be disenfranchising a larger number of people than if the successful candidate for the smaller profession were replaced. We were therefore advised by the Electoral Reform Society that it would be best to put similar sized professions together, so that the relative numbers of voters being disenfranchised would not vary too widely by profession in any one year.

[5] The Health Professions Order 2001

Your responses

We appear to have confused a number of respondents by talking about our proposals to group similar-sized professions together. For instance, the College of Occupational Therapists said that we should not have consulted on how we group the professions together "as this … is a matter of a separate consultation [about the structure of the register]". This response appears to have conflated the grouping of electorates together for the purposes of running elections and the grouping (or not) of professions into parts of our register (e.g. putting members of two different professions together as a single part of our register). While the election arrangements depend partly on the structure of the register, the grouping of electorates is an issue requiring urgent attention while the register structure is a longer-term issue. Consequently, we believe we were right to consult on how we plan to run elections—even if we need to modify the arrangements in the future in the light of changes to the register's structure. However, we now believe we should have talked about grouping similar-sized electorates together, as this would have made clear that our proposals were about the administration of our election scheme and had nothing to do with the representation of professions on our Council. We are sorry for any confusion that this caused.

A number of respondents were satisfied with our proposals to group similar-sized professions together, while others said they would be satisfied with either option. For example, the Hospital Play Staff Education Trust said that "a similar sized group of professions affords equity in the voting process which the Hospital Play Staff Education Trust endorses".

However, many respondents, including the AODP, the British Association for Counselling and Psychotherapy, and the BAPT, said that we should have made clear why we have changed our proposals from the proposals in our original consultation. We had initially decided to group electorates together such that the total number of votes cast in elections each year was roughly the same. Respondents were right to point out that we had not explained why we had made this change and we are sorry that we did not do so. We agree that we should have done this, and we are sorry that we did not. We have included an explanation (above) of why we made the change.

By not having previously explained why we made this choice, we believe that we may have engendered some additional negative responses from organisations who had no basis for judging whether the new arrangements were better and therefore preferred the original proposals. The BAPO provides an example of this, commenting that "we would have thought it more sensible to balance the election by grouping the professions in order to have elections of similar size".

Several respondents commented on the fact that we have not said which professions will be grouped together. This is because we do not have the final authority over this decision—the Health Professions Order says that the Privy Council will decide this. This also means that we may not have the power to take up the suggestion from the Federation of Healthcare Science (also voiced by the Institute of Biomedical Science) that we start the elections cycle with the smaller professions, as "this would give the opportunity to bed in the election process without the added pressures of logistics that are associated with a large electorate".

The BAPT commented that the new proposals might give smaller professions a stronger voice, as (during elections) "they will not be putting their case alongside larger professions".

The BDA suggested that, once the procedure for grouping professions together has been decided, "it should follow a full cycle and not be changed midway".

A number of respondents had concerns about the loss of 'institutional memory' with all council members standing down for the elections of 2005. The SBBIOS said, for instance, that "the experience of present members will be lost". We understand that this is a risk and we will take steps to mitigate that risk as far as possible (by keeping detailed records of working,

for instance). It is also worth bearing in mind that current registrant and alternate council members are free to stand for election, and that lay members can be re-appointed by the Privy Council. Both these factors could reduce the degree of loss of institutional memory. However, we cannot institute any rolling cycle of elections in 2005 as suggested by a number of respondents, as the law says that all council members must stand down[6] at the same time in that year.

Key decisions

We will group professions of similar sizes together as set out in our proposals. We will work to ensure that registrants and organisations are properly informed about how the grouping will work. This will form part of the information we provide in the documents we produce that explain how our elections work.

We may change how electorates are grouped together in the light of any major changes to the structure of the register (which is the subject of a separate consultation).

4. Other comments

We had a number of other comments on aspects of our proposals. These included some comments on the consultation itself. Some respondents suggested that we should have used simpler language in the document and the rules. We tried to write both documents clearly, and we agree that there is more that we could have done. However, the rules will inevitably be complex and difficult as they must be precise and they are dealing with a complicated subject. As we have mentioned above, we will produce documents to help registrants and organisations understand our elections process and we will work with the Plain English Campaign to do this. We have also tried to write this document clearly.

CSP Wales said that we should consider how we communicate with our Welsh registrants, and with the public in Wales. We always try to make our publications accessible, and we provide on-demand translation of key information (which includes all documents related to consultations). We recognise that we could, instead, arrange to have all documents translated into Welsh (and other languages and formats) by default, but we believe that our registrants would generally be unsupportive of this move, given the high levels of costs involved, particularly as all our registrants are required to be proficient in English. Key documents are always translated into Welsh, including documents aimed at the public. We do keep this policy under review.

Several respondents thought that we should have consulted for longer than six weeks and should have circulated the consultation more widely. For example, the CSP said that "a time-frame of six weeks to respond to this consultation is insufficient", while the NIHPCLG said that the "shortened consultation period and reduced circulation list makes open and fully inclusive consultation difficult to achieve…". Of course, long consultation periods and extensive circulation of proposals allow larger numbers of people to respond; however, there is also a cost involved. As we have previously consulted on the principles of our elections process as part of our initial consultation in summer 2002, we believed that a shortened consultation period and circulation list was appropriate. This is particularly the case given the relatively technical nature of this consultation. On matters of wide interest, we will always consult for twelve weeks (e.g. our proposals for a CPD scheme).

We had proposed that the Council had the option of filling vacancies through by-elections, but was not required to do so. The COT stated that vacancies should always be filled through by-elections. We agree and have modified our rules accordingly.

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[6] The Health Professions Order 2001, Schedule 2, Paragraph 4: "…each member shall hold office until the end of the second transitional period." The second transitional period will end in 2005.

We had proposed that each candidate should have six nominators. The ICP argued that the number of nominations required by candidates should be more than six, and recommended 10 or 12. However, they did not explain why they thought six was too few, and as our proposals are in line with the practice of other regulators and no other respondents have asked us to increase this number, we have chosen to retain the requirement for six nominators only.

The BAPT suggested that we make nomination of candidates for election an electronic process as well. We think that this could be a useful approach and will explore the viability of doing this.

What happens next

Our rules have to be approved by the Privy Council. This may mean that they require us to change our approach substantively to approve the rules. Once the Privy Council has approved our rules, we will publish further documents outlining our election scheme. This will include a clear explanation of any substantive changes to our approach. We hope to do this in late 2004.

Who responded to the consultation document

Association of Clinical Biochemists
Association of Clinical Scientists
Association of Operating Department Practitioners
British Association for Counselling and Psychotherapy
British Association of Play Therapists
British Association of Prosthetics and Orthotists
British Chiropody and Podiatry Association
British Dietetic Association
Chartered Society of Physiotherapy
Chartered Society of Physiotherapy Wales
College of Occupational Therapists
Scottish Branch of the British and Irish Orthoptic Society
Federation for Healthcare Science
Hospital Play Staff Education Trust
Institute of Biomedical Science
Institute of Chiropodists and Podiatrists
Northern Ireland HPC Liaison Group
Patrick McCance
Privy Council Office
Regional Laboratory for Toxicology
Royal College of Speech and Language Therapists
Society and College of Radiographers

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