Council meeting, 18 September 2012

Regulating the adult social care workforce in England

Executive summary and recommendations

Introduction

In February 2011, the Command Paper 'Enabling excellence' said that the Department of Health (DH) would work with the HCPC to explore the scope for establishing a voluntary register for adult social care workers in England.

The attached paper invites the Council to agree the basis upon which the Executive should work with the DH in relation to this policy. It is planned that a draft policy statement will be considered at the following meeting of Council, informed by discussion at this meeting.

Decision

The Council is invited to discuss the attached paper and to agree the following statements.

- The HCPC has not changed its decisions to recommend that various aspirant groups should be statutory regulated.
- The HCPC as a statutory regulator will not establish voluntary registers without protection of title and/or a statutory link to the regulation of services.
- A 'negative register' for adult social care workers in England should be explored further, alongside the regulation of registered managers of care homes, subject to the Government funding the cost of this work.

Background information

See paper

Resource implications

None as a direct result of this paper; please see paper for description of possible future resource implications.

Financial implications

None as a direct result of this paper; please see paper for description of possible future financial implications.

Appendices

None

Date of paper

6 September 2012

Regulating the adult social care workforce in England

Author: Marc Seale

HCPC Council meeting, 18 September 2012

6 September 2012

1. Introduction

1.1. The purpose of this paper is to invite the Council to agree the basis upon which the Executive should work with the Department of Health to implement the Government's 2011 recommendations on the regulation of the adult social care workforce in England. The meeting of the Council on 18 September 2012 is its first meeting since the responsibility for the regulation of social workers in England transferred to the HCPC.

1.2. If the Council agrees in principle to the policy proposals articulated in this paper, its decisions and discussion will inform a draft HCPC policy statement to be considered at the Council meeting in October 2012.

1.3. If the Government subsequently considers that any of the proposals satisfy its policy objectives, then a significant amount of further work is likely to be required. In particular, this would need to include a thorough analysis of the costs of establishing any new systems of regulation; work with key stakeholders; and formal consultation.

1.4. On 1 August 2012, the Health Professions Council (HPC) became the Health and Care Professions Council (HCPC). This paper refers to the HCPC throughout.

2. Policy context

'Enabling Excellence'

2.1. The Command Paper 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers' was published by the Government in February 2011. The Command Paper made a series of recommendations about statutory regulation and the regulation of adult social care workers in England.[1]

2.2. It set out a range of decisions concerning the future of the statutory regulation. In particular, it said the following.

> 'The extension of statutory regulation to currently unregulated professional or occupational groups, such as some groups in the healthcare science workforce, will only be considered where there is a compelling case on the basis of a public safety risk and where assured voluntary registers are not considered sufficient to manage this risk.' (Paragraph 4.12)

2.3. In relation to adult social care workers in England it said the following.

> 'In chapter 4, we set out our proposals to put in place a system of assured voluntary registration for professionals and occupational groups which are currently not subject to statutory professional regulation. It is our view that this model should apply to the adult social care workforce and we will explore scope for the HPC to establish a voluntary register of social care workers by 2013. We envisage that in future local authority commissioners would be able to give preference to adult social care providers using workers on voluntary registers and that this could be a factor taken into account in the CQC's proposals for an excellence scheme which it will be consulting on.' (Paragraph 6.16)

2.4. The regulation of social workers and social care workers is devolved to each of the four countries and therefore the Command Paper and the proposals in this paper relate to England only.

[1] Department of Health (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359

2.5. Further, the policy outlined in the Command Paper applies to social care workers who work with adults only. The Department of Health holds responsibility for adult social care only; responsibility for the children's workforce rests with the Department for Education. Although the arrangements discussed in this paper might potentially be scalable to the children's workforce (and, indeed, to support workers in healthcare), this paper focuses on adult social care workers in England.

2.6. The CQC 'excellence scheme' referred to in paragraph 2.3 is no longer being implemented after the proposals were poorly received by stakeholders. However, we understand that a sector-led approach may be being explored.

2.7. The policy intention to introduce voluntary registration for adult social care workers in England was re-articulated in the recent Care and Support White Paper which referred to work being carried out by Skills for Health and Skills for Care to develop a code of conduct and induction standards for support workers. The Paper said:

> 'The conduct and training standards will also support the introduction of assured voluntary registration of adult social care workers and healthcare support workers, which will further contribute to improving standards.'[2]

2.8. On 1 August 2012 the statutory register of social workers in England was transferred from the GSCC to the HCPC. Now that this task has been completed, there is the opportunity to begin to explore in more detail how the adult social care workforce in England might be regulated.

Statutory Regulation

2.9. In relation to the delivery of health and care services, statutory regulation is a tried and tested method of enhancing public protection by setting and improving the standards of professionals. This can be achieved because statutory regulators are given a portfolio of interlinked legal powers. These powers relate to the following.

- Establishing mandatory national standards.
- Management of fitness to practice cases.
- Criminal powers to protect titles and (in a small number of examples) functions.

2.10. However, statutory regulation may not be the most appropriate mechanism in every situation. Statutory regulation can be costly to administer and is typically funded by those who are regulated. There is also evidence that regulation has

[2] Department of Health (2012). Caring for our future: reforming care and support. http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

the effect of increasing the wages of registrants relative to other individuals who are not statutory regulated.[3]

2.11. Article 3 (17) of the Health and Social Work Professions Order 2001 permits the Council to make recommendations to the Secretary of State for Health and Scottish Ministers concerning any profession which in its opinion should be regulated pursuant to section 60(1)(b) of the Health Act 1999.

2.12. To date, following recommendations by the Council two new groups have been brought into statutory regulation.

- Operating Department Practitioners – register opened October 2004.
- Practitioner Psychologists - register opened July 2009.

2.13. However, recommendations were also made in relation to the following groups. In relation to five healthcare science groups (marked with '*' below), the Command Paper sets out that the Government does not intend to statutory regulate these groups.

- Clinical perfusionists*
- Clinical physiologists*
- Dance movement psychotherapists
- Clinical technologists*
- Medical illustrators (clinical photographers)*
- Maxillofacial prosthetists and technologists*
- Genetic counsellors
- Sonographers
- Sports therapists

2.14. It should be noted that the Government is moving ahead with the statutory regulation of non-medical public health specialists and of herbal practitioners (including medical herbalists and traditional Chinese medicine practitioners).

2.15. The Council is therefore asked to agree the following.

The HCPC has not changed its decisions to recommend that various aspirant groups should be statutory regulated.

[3] For example: UK Commission on Employment and Skills (2011). A review of occupational regulation and its impact.
http://www.ukces.org.uk/publications/er40-occupational-regulation-impact

3. Voluntary registration

3.1. The Health and Social Care Act 2012 came into force on 27 March 2012. The Act provides the HCPC with discretionary powers to establish voluntary registers for professions and occupations but without the key legal powers associated with statutory regulation. These powers are discretionary. Establishing a voluntary register is made subject to undertaking an assessment of the impact of doing so and holding a public consultation.

3.2. The Council has discussed the issue of voluntary registration on a number of occasions, and has expressed some concern about the feasibility and desirability of this approach. In its most recent discussion, the Council agreed three factors which were important in any proposals for voluntary registration by the HCPC.[4]

- Finances and funding. Government funding would be required to cover the start-up costs of voluntary register and until any register reaches a break-even position.
- Business model. The model adopted for any voluntary register would need to be appropriate to the group, proportionate to the risk and cost-effective.
- Linkage. For any voluntary register to be meaningful, registration would need to be required or incentivised in some way - for example, by being linked to service regulation requirements.

Shortcomings of Voluntary Registers

3.3. The Council's view has been that, compared to statutory registers, voluntary registers have a number of drawbacks, which are perhaps more significant for the HCPC as a statutory regulator.

3.4. They include the following.

- There is no legal compulsion for an individual to join a voluntary register, although an employer can insist an employee is registered as part of an employment contract.
- The keeper of a voluntary register will not have legal powers to demand disclosure of information or to compel witnesses as part of dealing with fitness to practise issues. This will hinder any investigation and subsequent tribunals.
- There is nothing to prevent the setting-up by different organisations of more than one register for a single occupation or profession.
- A single nationwide set of education and training standards cannot be imposed on the profession or occupation.

[4] Council meeting, 9 February 2012. Voluntary registers. http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=605 (enclosure 06)

- Since no legislation is required to establish a voluntary register, there can be no protection of common professional titles. Therefore, an individual who does not join a voluntary register or who has been removed from a voluntary register will not commit a criminal offence if they continue to practise using the title for their profession.

Protection of common titles

3.5. The HCPC's predecessor organisation the Council for Professions Supplementary to Medicine (CPSM) had over 35 years of experience of regulating professions without the power to protect common titles. 'Protection' in this context means that under UK law the use of the title by those who are not on the register of the statutory regulator is a criminal offence. In relation to the HCPC, the power is caveated that the HCPC will only intervene if there is the improper use of the title 'with the intention to deceive'.

3.6. Under the CPSM's legislation, the titles of healthcare professionals such as 'physiotherapist' or 'chiropodist' were not protected, meaning that they were not reserved solely to those who were CPSM registered. The Act only protected those using professional titles in combination with the suffix 'State Registered' ('SR'). State registration was only required for those wishing to work with the NHS or other publicly funded services. As a result they continued to be used freely in the private sector, including potentially by those with no relevant qualifications and/or experience.

3.7. In April 1996 the UK Health Departments commissioned J.M. Consulting to review the working of the Professions Supplementary to Medicine Act 1960. Their report made a number of recommendations that were subsequently adopted by the then Government in new legislation which established the HCPC in April 2002. A finding of the report was the identification of a key weakness in the CPSM legislation in that it did not have protection of title powers. The report said the following.

> '…the term State Registered (SR) is probably not recognised by the majority of patients, and they could not be expected to distinguish between the various training and education courses followed, nor the type and level of experience offered by the practitioner.' (Paragraph 5.41)[5]

3.8. In 2001 and 2002 during the brief period when the HCPC operated as a shadow organisation, we received numerous complaints from members of the public about individuals using the common title and not the SR title. Typically

[5] JM Consulting (1996). The regulation of health professions: a report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4005411

members of the public did not understand why the regulator could not intervene and were in turn critical of the regulator for its perceived inaction.

Protection of function

3.9. In addition to protection of title there is an alternative method of statutory regulating professionals, less commonly used in the UK, called 'protection of function'. In this case the legislation defines the activities or acts can only be undertaken by those who are registered. For example, the dispensing of hearing aids for retail supply or hire by HCPC registered hearing aid dispensers is a protected function. Other protected functions include the fitting and prescribing of contact lenses by GOC registered optometrists and midwifery by NMC registered midwives.

HCPC and voluntary registers

3.10. It is clear that voluntary registers managed by a statutory regulator have a number of specific risks in relation to communication, reputation and credibility.

3.11. If the HCPC was to open a voluntary register it is reasonable to assume that some employers would insist on only employing those individuals who were registered but inevitably some would not. Under the CPSM arrangements the Department of Health issued circulars requiring NHS employing organisations to only employ or contract with state registered individuals. However, the policy was not always adhered to and it did not address the delivery of services in the independent sector. It is interesting to speculate that some employers with less rigorous ethical standards or who are less financially robust would have a propensity to follow this route. Cases would also arise where complaints were made about individuals who were no longer registered or who had never been registered. The HCPC would be unable to take any action. Such individuals would be able to continue working legally without registration.

3.12. This issue was addressed in the Command Paper.

> 'No staff will be compelled to join these registers and employers will not be required to employ staff from these registers, though they could choose to do so. Where providers and those that they provide care for see benefit in employing staff who are nationally assured through a voluntary register, they will be able to do so, either by requiring registration when advertising posts, or seeking a commitment to join a register and training and developing existing staff so that they are able to do so.' (Paragraph 5.41)

3.13. In addition, as any register would be voluntary, someone subject to a fitness to practise finding would not have recourse to the appeal rights afforded to statutory regulated individuals. Although alternative arrangements could be put in place to ensure a 'fair trial' within the constraints of this approach, this is

perhaps an undesirable arrangement for all parties and particularly for a statutory regulator.

3.14. The HCPC is a public organisation with an overriding objective to protect the public. We operate in an arena that is subjected to a high level of media interest and scrutiny. We would therefore inevitably receive criticism for our lack of intervention in cases relating to non-registrants (see paragraphs 3.8 and 3.10 – 3.11). This in turn would have the potential to damage our reputation with all of our stakeholders.

3.15. Further, there remains some doubt, given the challenges outlined here, about the cost-effectiveness of voluntary registers maintained by the statutory regulators. The Council has previously agreed that any voluntary registers should be self-financing on an on-going basis, avoiding any significant cross-subsidisation from the organisation's statutory functions. As such, establishing a register for any group is likely to require significant funding to establish the register and then to subsidise its operation until a break-even point was reached.

Role of the Professional Standards Authority for Health and Social Care (PSA)

3.16. The Health and Social Care Act 2012 has given new powers to the CHRE, which is to be renamed the 'Professional Standards Authority for Health and Social Care (PSA)', to accredit voluntary registers. The CHRE has consulted upon and published standards for voluntary registers. Keepers of voluntary registers who meet the PSA's standards will be able to use the PSA 'Kite Mark'. The assumption is that users of services will then be able make an informed choice about from whom to source their heath and care services.

3.17. The PSA accreditation arrangements provide increased external oversight and an incentive for voluntary organisations to improve their processes. The proposed arrangements are therefore a clear improvement compared to an existing situation where there is no statutory regulation or external oversight. Further, it would be unreasonable to assume that many of the groups likely to seek accreditation from the CHRE would be likely to be subject to statutory regulation (at least in the medium to long term) even if there was a significant shift in Government policy on this topic. The Executive is therefore supportive of this approach in providing additional assurance.

3.18. However, the view of the HCPC Executive based on our experience of the CPSM arrangements and the drawbacks outlined in this paper, is that it is not appropriate for a statutory regulator to a establish voluntary registers without protection of title or some kind of strong and binding statutory link to the regulation of services which would compel registration. It appears unlikely that the Government would be willing to legislate to protect titles.

3.19. The Council is therefore asked to agree the following.

The HCPC as a statutory regulator will not establish voluntary registers without protection of title and/or a statutory link to the regulation of services.

4. A possible way forward

4.1. Although the Government is unable to compel the HCPC to open a voluntary register it is imperative that we should investigate all practical regulatory options. The HCPC and the Department of Health have exactly the same objective of increasing public protection in an efficient and effective way.

4.2. The remainder of the paper explores a potential proposal for regulating adult social care workers in England. This proposes that 'registered managers' of care homes might be regulated, alongside a 'negative register' which would regulate the remainder of the workforce. These initiatives have been proposed as a potential proportionate and targeted way of enhancing public protection.

4.3. The (voluntary) registration of adult social care workers in England has been positioned as part of an overall desire to improve the quality of services delivered by the sector. Further, the desire to avoid 'centralisation' wherever possible is also a key policy driver. As such, these proposals need to be viewed as complementary to other 'sector-led' approaches to improving quality. For example, Skills for Care and Skills for Health have been commissioned by the Department of Health to develop a code of conduct and common induction standards for health and social care staff. The terms of reference of this work are limited to adult social care workers in England and healthcare support workers in England that work to nurses. However, the products of this work are likely to be much more widely applicable and this is a positive step in helping to improve standards.[6]

Proposals for the regulation of 'registered managers'

4.4. The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. The CQC registers providers of health and social care including hospitals, dental practices and care homes.

4.5. The CQC model operates on the basis of regulated activities which are specified in law. A service provider performing one of these activities has to be registered with the CQC. For example, this includes personal care; treatment of disease, disorder or injury; and surgical procedures.[7]

4.6. All service providers registered by the CQC must have a registered manager for each of the regulated activities they carry out – that is a named manager who is responsible for the day-day-day supervision of each regulated activity carried out at that locality.

[6] http://www.skillsforhealth.org.uk/about-us/press-releases/training-standards-and-code-of-conduct/
[7] http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/regulated-activities

4.7. Although some registered managers may be statutory regulated professionals, others will not. The recent Winterbourne View hospital serious case review refers to establishing registered managers as a profession with a code of ethics and regulatory body to enforce standards.[8] Elsewhere in the UK the care councils have commenced the regulation of the social care workforce with the regulation of managers of care homes for children and adults.[9]

4.8. In discussion with the CQC, the number of registered managers has been estimated at around 15,000 individuals (although this may encompass registered managers for regulated activities outside of adult social care).

4.9. The managers of care homes provide a pivotal role in influencing the standards, culture and behaviour of their employees. It is therefore proposed in line with the serious case review findings that regulation of managers, by making them subject to an enforceable code of ethics, coupled with other arrangements for the remainder of the workforce (described later in this paper), might be a proportionate approach. The register of registered managers would either need to be maintained on a statutory basis, or else linked to CQC regulation such as to effectively compel registration.

Regulating the remainder of the adult social care workforce in England

4.10. The remainder of this section outlines the challenges to regulating the remainder of the adult social care workforce in England and proposes a way forward.

Number of titles

4.11. If regulation of individuals relies on service users being able to identify those who are regulated by their title, then only using one protected title is beneficial in terms of transparency and accessibility. If a profession or occupation uses many interchangeable titles then the task of regulation can be more challenging.

4.12. In the UK there are a limited number of examples when more than one title is protected, for example 'physiotherapist' and 'physical therapist'. The rationale for this is that in elsewhere in the world 'physical therapist' is used. If both titles were not protected someone who was a 'physical therapist' would potentially be able to work in the UK without registering with the HCPC.

4.13. When numerous titles are used, protecting all the tiles is not a viable solution, partly because further titles are created and used by those seeking to avoid regulation. A range of different occupational titles will be used by those who

[8] HCPC response to serious case review report, including link to full report: http://www.hcpc-uk.org/mediaandevents/news/index.asp?id=497
[9] Northern Ireland Social Care Council (NISCC); Care Council for Wales (CCW); and the Scottish Social Services Council (SSSC).

work in adult social care and therefore it would not seem viable to regulate on this basis in any event.

Number of registrants

4.14. The number of registrants is a key issue to be taken into account whenever considering extending regulation. There are a number of challenges including the following.

4.15. Firstly, forecasting the number of individuals who will join a newly opened register if a profession is brought into statutory regulation is inexact. Organisations that are in favour of statutory regulation tend to overestimate the numbers, possibly to increase their bargaining position. Those against the inclusion of the aspirant profession into a statutory regime have tended to underestimate the numbers, possibly to demonstrate that legislation is not appropriate because of the small size of the perceived problem. In addition, where there is more than one professional body (if they exist at all), double counting occurs due to dual memberships.

4.16. Secondly, there is a perceived difficulty if the number of individuals who could be on a register is considered to be 'too large'. In the current economic and political climate there is concern about bringing large numbers within a statutory regulation framework, owing to the cost involved and questions of proportionality.

4.17. The adult social care workforce in England has been estimated at 1.56m individuals.[10] In 2009 there were an estimated 17,300 organisations in England providing or organising social care for adults and older people and employing social care workers in the adult care sector alone. Adult home care workers have been estimated as numbering 412,000 individuals.[11] The Command Paper sets out the Government's view that it 'does not believe that the extension of statutory regulation to all workers in the health sector across the UK and the social care sector in England would be a proportionate response'.[12]

Cost of regulation

4.18. The Government is rightly concerned about the cost of regulation both in terms of cost to individual professionals or occupations and to employers. This is a particular challenge in considering how adult social care workers in England should be regulated.

[10] Skills for Care (2011). The size and structure of the adult social care workforce in England. http://www.skillsforcare.org.uk/research/research_reports/size_and_structure_2011.aspx
[11] Enabling excellence, paragraph 6.9
[12] Enabling excellence, paragraph 4.2

4.19. In previous initiatives looking at regulating the adult social care workforce in England, it has been noted that the workforce as a whole is generally characterised by relatively low rates of pay and part time working. The statutory regulation model operated by the HCPC entails a yearly fee of £76 per year. Such a fee is likely to represent a disproportionate burden either on relatively lowly paid adult social care workers, or their employers if they covered the cost.

4.20. In the other countries, the fees paid by social care workers often vary with managers paying a larger fee. However, the cost of regulation of workers is in part subsidised through grant-in-aid by the devolved administrations. Further, given existing government policy, it appears unlikely that the Government would contemplate significant medium to long-term subsidisation of the cost of voluntary or statutory regulation.

Social Work Student Suitability Scheme in England

4.21. The principles and processes underpinning the social work student suitability scheme, recently put in place to manage the transition from the registration of social work students in England by the GSCC to our arrangements, might offer a potential solution to these challenges.

4.22. The scheme enables us to:

- provide an opinion, in exceptional circumstances, to a social work education provider on whether an applicant is of suitable character to be admitted to a programme;
- investigate where we consider that the education provider has failed to deal with a credible complaint about a student appropriately;
- consider the outcomes of an education provider's fitness to practise procedures to determine whether a student should be prohibited from a programme;
- maintain a record of students who are not permitted to participate in a social work programme in England; and
- manage open cases (at the time of transfer) concerning individuals applying to be on the student register maintained by the GSCC and those individuals who are on the GSCC student register.[13]

4.23. The scheme uses a number of processes that might potentially be used in relation to the regulation of adult social care workers.

- No register of social work students in England is maintained. As there is no register, students do not have to pay any registration fees.
- The hearing used to determine if a student should be prohibited makes use of a single adjudicator rather than a three person tribunal panel.

[13] http://www.hpc-uk.org/education/studentsuitability/

- The suitability scheme is a proportionate approach. It ensures overall responsibility for dealing with student conduct issues rests with the education provider, whilst providing an important backstop which allows education providers and employers to easily identify who should not be participating in programmes and practice placements.

'Negative licensing' in Australia

4.24. In New South Wales (NSW) a similar approach has been used since 2006 for regulating health practitioners who are not subject to statutory regulation, referred to as a 'negative licensing scheme'. There is currently a proposal to extend the scheme to other territories and states in Australia. This proposal follows an extensive public consultation on the options for unregulated health practitioners across Australia.[14] The key features of the scheme are as follows.

- The scheme applies to all practitioners offering a health service defined in NSW legislation. Practitioners are not required to register with the scheme.
- A statutory code of conduct for unregistered health practitioners is published. This is similar to the HCPC's standards of conduct, performance and ethics in intent, covering areas such as ethics and personal conduct as well as infection control, substance misuse and record keeping.
- Complaints about unregistered practitioners can be considered by the NSW Health Care Complaints Commission against the code of conduct.
- A complaint may be upheld if in the opinion of the Commission the individual poses a significant risk to the health and safety of members of the public.
- The Commission can warn the individual; issue an order prohibiting the individual from providing health services for a period of time or permanently; or issue conditions. Breaches of orders are prosecuted through the courts.

4.25. The cost of the scheme has been low, as a relatively small number of cases have been dealt with to date. Since the scheme was launched, there have been approximately 200 complaints about unregistered practitioners. 31 were investigated and 9 prohibition orders have been issued.

4.26. The costs of extending the scheme to the rest of the Australian states and territories are estimated to be approximately up to £400,000 for set-up costs and £345,000 per year running costs (excluding existing NSW costs). This compares to approximately £53m per year if statutory regulation was extended across a wider range of professions and groups.[15]

[14] Australian Health Ministers Advisory Council (2011). Options for regulation of unregistered health practitioners.
www.ahmac.gov.au/

[15] Conversion from AUD to GBP correct at time of writing this paper. Figures are unconfirmed estimates.

Negative registration

4.27. ‘Negative registration’ of adult social care workers in England might be consistent (when taken in combination with the other measures discussed in this paper) with the Government’s policy agenda on proportionate management of risk, whilst providing reassurance to the public that there is a process to ensure protection from harm.

4.28. Such a scheme would help to address the concerns raised about the conduct and regulation of support staff, recognising that an increasing proportion of care is now delivered by staff not required to undergo any nationally agreed or uniform training or to be registered by any regulatory body.

4.29. The registration scheme might work in a similar manner to the scheme in New South Wales. A code of conduct for adult social care workers would be published. Complaints could be considered against the code and, where there was a significant risk to public safety, a decision made about whether to prohibit an individual for a defined period or permanently, to apply conditions or to warn them. This might be linked to a CQC regulated activity so that, for example, an individual could not carry out, or be employed to carry out, a relevant regulated activity if they had been ‘negatively registered’.

4.30. The following describes the potential benefits.

- A code of conduct with a status in law would apply to all adult social care workers, encouraging minimum standards in the sector.
- The scheme would provide a mechanism for considering serious complaints and for taking effective action to prevent continuing harm to service users.
- Information about decisions would be available publicly to service users and employers.
- The scheme would provide a backstop rather than appearing to replace the responsibility of employers to deal effectively and swiftly with instances of poor conduct by their workers.
- The scheme would be a proportionate approach by targeting regulation at the area of greatest potential risk to service users. The scheme would complement regulation of registered managers with responsibility for care homes and sector-led approaches which are aimed at improving standards.
- The costs involved would be proportionately lower than statutory regulation as individuals would not be required to register and pay a fee; education and training programmes would not be approved; and the threshold for considering complaints would be higher.
- The model would permit employers continued flexibility in deciding how to deploy staff to develop and deliver their services.
- The scheme would provide higher levels of public protection than purely voluntary or self-regulatory arrangements.

- Although this paper focuses on the adult social care workforce, the model could potentially be scale-able to other parts of the workforce.

4.31. There are two key areas that would particularly need to be considered further.

4.32. The first is cost. If the Government considered that the scheme may be consistent with its policy objectives, further work would be needed on modelling the likely costs.

4.33. Assuming the scheme was managed by the HCPC, many fixed costs have already been funded. However, a system for the scheme to fund a proportion of fixed costs would need to be devised and apportioned.

4.34. It is assumed that the Government would have to fund the cost of establishing the scheme. It is assumed that grant-in-aid would have to be paid to the HCPC, possibly at a fixed term of three to four years. To encourage the delivery of a cost-effective scheme, it may be possible for the Government to undertake a periodic retendering exercise that would enable interested organisations to bid to provide the service.

4.35. The second is interaction with the vetting and barring scheme operated by the Independent Safeguarding Authority (ISA) in England. The scheme is being reformed following a recent review.

4.36. Under this scheme, the ISA is able to bar individuals from working with vulnerable children or adults. There are a range of serious criminal offences which automatically lead to barring under the scheme. They include convictions for rape, sexual assault, trafficking and abduction. Other matters, which may include the decisions of regulatory bodies and so-called 'soft information' referred for example by employers or the police, are also considered and a decision made about whether that person should be barred. The ISA considers whether, on the basis of that information, there is a risk of future harm to children or vulnerable adults.

4.37. The HCPC refers the outcomes of fitness to practise cases to the ISA where it is considered that there may be risk to children and/or vulnerable adults and these include many cases where a striking-off order has been made by a panel. In our experience, the ISA applies a high threshold and only a proportion of these cases have led to a barring decision being made.

4.38. The negative registration model is similar in some respects to these arrangements. For example, ISA maintains a list of barred individuals; individuals are not required to positively register.

4.39. However there are some key differences between ISA barring arrangements and the negative registration model (as operated in NSW).

- Negative registration entails a code of conduct which would apply to the adult social care workforce.
- A range of sanctions are available including suspension, conditions and warnings whereas the decision for ISA is whether to bar or not.
- The ISA scheme applies a higher threshold than would be in place for negative registration.
- The outcome of an ISA barring decision prevents someone from working or volunteering with children or vulnerable adults. The outcome of a prohibition decision as part of the negative registration scheme would be about performing adult social care. The decisions involved are therefore different.
- The negative registration scheme would allow 'professional conduct' issues such as appropriate care; treating patients with dignity and respect; and breaches of confidentiality to be dealt with effectively.

4.40. However, the interaction of the two schemes would need to be explored further. In addition, establishing in clear terms the threshold for considering issuing a warning, conditions or a prohibition order under the negative licensing scheme would be important to ensure this arrangement was proportionate, targeted and cost-effective.

4.41. The Council is invited to agree the following.

A 'negative register' for adult social care workers in England should be explored further, alongside the regulation of registered managers of care homes, subject to the Government funding the cost of this work.

5. Timetable

5.1. There are a number of other Government initiatives which would affect the timetable for considering the regulation of adult social care workers in England further.

5.2. The Government has announced that the size of the Council of the HCPC should be reduced from its current membership of 20 to 12. Similar exercises have recently concluded that have resulted in a reduction of the size of the Council of the General Medical Council (GMC) and the General Dental Council (GDC) to 12 members. The Department of Health has not yet published its consultation document but it is assumed that the new arrangements will be in place by July 2013. The changes to the HCPC legislation will be facilitated by legislation in the form of a Section 60, which must be approved by the both the UK and Scottish Parliaments.

5.3. A negative register approach would require legislation and changes to legislation may also be required to facilitate the regulation of registered managers. The legislation referred to above may be likely to limit the scope for additional legislation in this area, at very least within this parliament.