professional standards authority

Response to the Welsh Government White Paper: The Future of Regulation and Inspection of Care and Support in Wales

January 2014

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care[1] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care.[2] We are an independent body, accountable to the UK Parliament, and report annually to the National Assembly for Wales.

1.2 As part of our work we:

- Conduct research and can advise Welsh Ministers on improvements in professional regulation[3]
- Promote Right-touch regulation and publish papers on regulatory policy and practice
- Oversee nine health and care professional regulators[4] and provide annual reports on their performance to the UK and Scottish Parliaments and the Northern Ireland and Wales Assemblies
- Conduct audits and investigations and can appeal fitness to practise cases to the courts if sanctions are unduly lenient and it is in the public interest
- Accredit voluntary health and care occupational registers to improve consumer protection and raise standards.

1.3 More information about our work and the approach we take is available at www.professionalstandards.org.uk.

1.4 We welcome the opportunity to respond to this Welsh Government consultation on its future policy for the regulation and inspection of care and support in Wales ('the White Paper').[5] We make the following comments in the interests of the effectiveness and efficiency of regulation in the care sector. Given our focus on statutory professional regulation and voluntary registers our response focuses on those aspects of the White Paper. However, we have also

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[1] The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence (CHRE)

[2] Our statutory remit is UK wide in respect of patients and people who work in health. In relation to users of social care and social work services and people who work in the care sector our statutory remit extends to England only (*National Health Service Reform and Health Care Professions Act 2002* (as amended), section 25).

[3] We regularly provide advice to the Secretary of State for Health and Ministers on a UK wide basis through a joint commissioning arrangement led by Department of Health

[4] General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

[5] Available at http://wales.gov.uk/consultations/healthsocialcare/support/?lang=en

responded to some of the service regulation questions where we believe our experience may assist.

2. The policy aims

2.1 We support the policy aims and objectives listed in paragraphs 15 to 18 of the White Paper and note in particular the commitment to delivering value for money and developing a regulatory framework that is proportionate to risk and does not require additional funding. Regulation should be used judiciously because of its economic impacts. Too much regulation is a waste; too little is ineffective.

3. Statutory workforce regulation

Extending workforce regulation (Questions 23 to 25)

3.1 Paragraph 101 of the White Paper explains that the Welsh Government is considering introducing legislation which will enable statutory regulation to be extended to new care and support workforce groups 'when necessary and appropriate'. It is unclear whom the government proposes to give this power to. We think it should be the relevant government minister. Because of the socio-economic impacts of statutory regulation, we do not think such a power should be conferred on a regulator or any other body outside government.

3.2 Paragraphs 101 and 102 invite views on whether the government should extend registration to foster carers, care inspectors and staff whom provide the advocacy services the Social Services and Well-being (Wales) Bill would introduce. We are unclear if the use of the word 'registration' rather than 'regulation' is significant here. In our view they are different models of assurance. For clarity, in this response, when we refer to regulation we refer to statutory regulation which includes formal fitness to practise proceedings against people who fail to meet the regulator's standards. The holding of a register is a basic element of most forms of statutory regulation. However registers (that is a list of recognised practitioners) can also be held by other public bodies, professional organisations or employers and do not involve formal fitness to practise proceedings.

3.3 We recommend that the Welsh Government applies the principles of right-touch regulation when assessing whether, and how, to extend workforce regulation or registration in Wales.

Right-touch regulation

3.4 *Right-touch regulation*[6] is the approach that we encourage the professional regulators we oversee to work towards, and it frames the contributions we make to wider debates about the quality and safety of health and social care and the development of regulation. It is also the approach we apply to our own work.

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[6] CHRE, 2010. *Right-touch regulation.* Available at: http://www.professionalstandards.org.uk/library/document-detail?id=a3ea5638-fadf-400e-8635-47bf4b028a1f

3.5 Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent. It means applying the minimum regulatory force required to achieve the desired result. It complements the well-established principles of good regulation and is outlined in the following eight steps:

- Identify the problem before the solution
- Quantify the risks
- Get as close to the problem as possible
- Focus on the outcome
- Use regulation only when necessary
- Keep it simple
- Check for unintended consequences
- Review and respond to change.

3.6 Applying right-touch regulation helps us to answer questions about the appropriate assurance framework for different groups working in health and social care. It recognises that there is usually more than one way to solve a problem and that statutory regulation is not always the best answer. It also ensures agility. Workforce needs are constantly changing and it is important that regulation supports rather than constrains changes in deployment of staff where this benefits patients and service users. Alternative solutions should therefore be considered such as licensing, voluntary registers and employer-led codes of practice.

3.7 We believe that any decisions to statutorily regulate a professional group should be based on an assessment of the risk that the group poses to the public, and whether statutory regulation is the most appropriate and effective response to that risk.

Student registration

3.8 Paragraph 97 states that the groups already regulated by the Care Council Wales will continue to be regulated by the workforce regulator. This includes students participating on a social work degree course in Wales.

3.9 We understand that registering students may help with administering the student bursary scheme. However we do not believe that statutory regulation of students is an appropriate response to any risks that might be posed or experienced by students of any currently regulated health or care professions.

3.10 Right-touch regulation tells us to use just enough regulatory force to achieve the desired result. In these circumstances, the nature of pre-registration training and the key role played by the education provider, lead us to conclude that proposals to manage student fitness to practise through a system of student registration fail this test.

3.11 By definition, students are not fit to practise: they are aspiring professionals rather than full members of the profession. Given this, it is not appropriate to

consider that the same regulatory approach is necessary during training as that which is used to manage the risks to public protection posed by fully qualified and registered professionals and other options should be actively explored. Our position is supported by the Principles for Better Regulation of Higher Education proposed by the Higher Education Better Regulation Group in November 2011[7] specifically that 'alternatives to regulation should be considered where appropriate'.

3.12 There are risks associated with students in pre-registration training such as poor performance, harm to service users, fraudulent re-enrolment and programme hopping. Service users can also pose risks to students. The key question is who is responsible for managing these risks? Statutory regulation is not and should not be a substitute for proper support and supervision of students.

3.13 In our view these risks should be the responsibility of education providers, working with employers as placement providers. These risks can be managed through the design and delivery of courses, including robust recruitment practices, clear admission criteria, embedding professionalism and standards of conduct throughout the course, and effective supervision. The regulator has a role supporting education providers, through advice and guidance on standards to be met and the management of fitness to practise issues among a student.

3.14 Deregulation clearly needs to be risk based but becomes an option where a quality assured alternative to statutory regulation exists. Steps may need to be taken to support the transition from statutory regulation to its alternative. The Health and Care Professions Council's social work student suitability scheme[8] is a highly relevant example of how a workforce regulator can support such a transition.

Protection of title/role (Questions 26 to 27)

3.15 Paragraph 99 explains that 'social worker' is currently a protected title however, for other statutorily regulated groups in Wales, such as adult care home managers, protection of role exists rather than protection of title. Questions 26 and 27 invite views on whether protection of title or protection of role should be extended across the register. We assume in this context that the word 'role' is used to mean occupation or position, rather than task or activity. If so we think the current arrangements should be sufficient, in the absence of any evidence to the contrary.

3.16 We have published a paper which explores how professional regulators can tackle the misuse of protected titles.[9] The Welsh Government may wish to review whether any legislative change is required to enable to the workforce regulator to apply the good practice identified in that report.

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[7] Higher Education Better Regulation Group, 2011. Principles for Better Regulation of Higher Education. Available at: http://www.hebetterregulation.ac.uk/OurWork/Pages/HEConcordat.aspx

[8] Information about the scheme is available at http://www.hpc-uk.org/education/studentsuitability/

[9] CHRE, Feb 2010. *Protecting the public from unregistered practitioners: Tackling misuse of protected title*. Available at: http://www.professionalstandards.org.uk/library/document-detail?id=79ad1501-7542-4051-a992-498603cb4783

Social care manager registration (Question 28)

3.17 We agree with the proposal in paragraph 103 to remove the requirement for managers to be registered with *both* the workforce regulator and the service regulator. Duplication of registers is inefficient and the confusion it creates can be counterproductive.

3.18 We note the proposal is for managers to register with the workforce regulator only. Intuitively it seems more sensible for the workforce regulator to hold this register. However, if the government considers the service regulator is better placed to identify and manage the risks associated with this work group it may be better for the service regulator to hold the register and regulate this group. Either way robust arrangements for intelligence sharing between the service and workforce regulator will be essential.

Maximising the public protection value of registers

3.19 We note that, with the exception of social workers, the Care Council for Wales' online register[10] does not reveal which profession(s) each individual registrant is registered for. Nor does the register show whether a condition has been placed on a registrant's registration. We consider this lack of transparency unhelpful.

3.20 We have published a paper which explores how statutory professional regulators can maximise their registers' contribution to public protection.[11] The Welsh Government may wish to review whether any legislative change is required to enable to the workforce regulator to apply the good practice identified in that report.

Specialist registers

3.21 Paragraph 100 explains the Welsh Government's plans to provide the workforce regulator (the Care Council for Wales) with the power to establish a register that reflects, and protects, different specialist or advanced roles within the social work profession. We recommend that the Welsh Government asses this proposal against the principles of Right-touch regulation as we did in our reports on advanced practice and managing extended practice among health professionals. [12]

3.22 In both of those reports we concluded 'Primary responsibility for the governance of new roles designed to meet the needs of the service provision environment should rest with employers and commissioners. ... Additional intervention by regulatory bodies would only contribute to public protection were the arrangements in place inadequately controlling the types of practice professionals were undertaking'.

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[10] Available at http://www.mycarecouncil.org.uk/en-gb/searchtheregister.aspx

[11] CHRE, 2010. *Health professional regulators' registers. Maximising their contribution to public protection and patient safety*. Available at http://www.professionalstandards.org.uk/library/document-detail?id=6375dd8e-8636-4e60-bab7-05a516c572ae

[12] CHRE, 2009. *Advanced Practice: Report to the four UK Health Departments*; CHRE, June 2010. *Managing extended practice: Is there a place for 'distributed regulation'?* Available at http://www.professionalstandards.org.uk/library/document-detail?id=c3c2f87e-f167-4e18-a2fa-284fc931132f and http://www.professionalstandards.org.uk/library/document-detail?id=021738e3-92fd-4929-b4ed-b28b56cdc909 respectively.

3.23 It is our firm view that a regulator should maintain specialist registers only if those roles pose a greater risk to service users and such additional regulation is the most appropriate and proportionate method of protecting services users from those risks. Such additional statutory regulation should not be introduced for the purpose of recognising professional status or career development.

A UK perspective

3.24 Research we commissioned in 2009 found that across the four countries of the UK, patients and other members of the public have shared expectations of healthcare professionals and their regulation.[13] It is probable that the same is true for care and support professionals and their regulation. We have also observed that public confidence in regulation depends in part on public understanding of the system and regulation's role within it. In light of this and the high levels of service user and workforce mobility within the UK and between the health and social care sectors, it would be helpful, once the Welsh Government's proposals are finalised, to consider how they will interact with other parts of the UK's care regulatory system and how those interactions can be best managed in the interests of the health, safety and well-being of the public. This is an approach the four Health Administrations of England, Northern Ireland, Scotland and Wales recognised in their joint response[14] to the 2009 report of the Extending Professional Regulation Working Group established to progress work in the 2007 White Paper *Trust, Assurance and Safety*. It would include considering the changes to UK legislation the UK government is expected to pursue in 2014 following the Law Commissions' review of law relating to the regulation of health care professionals in the UK and the regulation of social workers in England.

4. Voluntary registers (Question 29)

Clearly distinguishing voluntary registers from statutory regulation

4.1 Question 29 asks for views on the government's plans to remove voluntary registers from the workforce regulator. We support this plan because, as explained in our response to the UK government's White Paper *Equity and Excellence: Liberating the NHS*[15]*,* we believe that voluntary registration should be clearly distinguished from statutory regulation to avoid confusing the public and undermining the validity of either model. It is likely that if a regulator maintains both statutory (compulsory) registers and voluntary registers that the public may assume that their standards and controls are the same.

4.2 Further, we feel that the personal behaviours that drive a professional group to self-organise – a commitment to achieve higher standards – are unlikely to exist amongst groups that are 'hosted' by a statutory regulator. Notably, occupational

[13] Further information on this research is available on request
[14] Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102819.pdf
[15] CHRE, Oct 2010. *Proposals for CHRE's new roles and responsibilities*.

groups that have not self-organised in this manner include support workers and healthcare assistants.

4.3 This need not preclude statutory regulators from offering services to voluntary registers on a commercial basis, for instance managing a register on their behalf, but the two systems must remain visibly and distinctly separate. If the workforce regulator were to continue maintaining voluntary registers we would suggest a legislative requirement that the voluntary registers should operate on a full cost recovery basis, to ensure that those groups that are statutorily registered are not funding the voluntary register.

The Accredited Voluntary Registers (AVR) scheme

4.4 Paragraph 104 of the White Paper states that voluntary registers do '*not contribute to public assurance, can cause confusion for the public and allow workers of a low standard to fall through the net*'. The White Paper gives no evidence to support this assertion. Many existing voluntary registers do work effectively to protect the public. We have noted that those we have accredited have readily made changes to strengthen their arrangements where we identified a weakness during our assessment of them. Moreover, we urge the Welsh Government to clarify that its statement does not extend to the voluntary registers accredited by the Professional Standards Authority's Accredited Voluntary Registers scheme.

4.5 The best protection comes from individual professionals taking personal responsibility for the care they provide. This is a requirement for statutory regulation but there is no doubt that voluntary registrants also commit themselves in a similar way. There are a wide range of health and care occupations in the UK where practitioners are not required by law to be statutorily regulated. Many of these occupational groups have formed organisations whose role is to develop and maintain standards of professionalism in their area of practice. Frequently, these organisations hold registers of practitioners who commit to meet certain standards of conduct and competence. Many of these organisations act as representative bodies, promoting the interests of their occupational group.

4.6 The Professional Standards Authority's Accredited Voluntary Registers scheme exists to provide assurance that accredited registers are well run and require their registrants to meet high standards of personal behaviour, technical competence and, where applicable, business practice. Furthermore we require accredited registers to recognise each other's disciplinary decisions and reports concerns about their registrants to relevant agencies. This means that the perceived loophole by which registrants may leave a voluntary register and continue to practice may be avoided by only employing or using the services of people who are on an accredited voluntary register.

4.7 In order to be accredited under the scheme registers have to meet demanding standards in the following areas: governance, setting standards, education and training, managing the register, providing information and complaints. Organisations holding voluntary registers have to provide evidence and demonstrate to the Authority that they meet the Accreditation Standards. To

ensure that these standards continue to be met, accreditation is renewed annually.

4.8 When accredited, organisations holding registers are able to display the Authority's registered AVR symbol and will be listed in the Accredited Registers Directory on the Authority's website. Since the scheme launched in January 2013, nine voluntary registers have been accredited covering 20 occupations and approximately 45,000 registrants.

5. Negative registers (Questions 30 to 32)

5.1 Paragraphs 105 to 107 discuss the concept of negative registration and invite views on its risks and benefits. The Authority has not yet established a final position on negative registers. Our early thinking on the topic is set out below.

5.2 There are now a number of different models used to control the safety and quality of health and social care workers in the UK, for example, employer-led approaches, assured voluntary registration, as well as established statutory professional regulation. Choosing the most appropriate model for a particular group relies upon an understanding of the risks presented by that group, the existing regulatory and contractual frameworks, and prevailing workforce issues.

5.3 Negative registration might appear to be a new approach to controlling the safety and quality of health and social care workers. However, with national vetting and barring schemes already in place, for example the Disclosure and Barring Service, it appears that there is already a system of negative registration in place for this particular group.

5.4 The question is therefore what additional benefits, if any, would a negative register for care and support workers offer service users, the public and employers, and what would it cost to deliver these benefits? A negative register would not stop an initial instance of harm to a service user or misconduct by a social care worker because action could only be taken after an event. The effectiveness of this model would rely upon the effectiveness of the complaints handling process that could lead to barring decision, keeping the worker and key witnesses engaged in the scheme's actions to secure a barring decision. This could be a lengthy process. We consider that there would be a number of issues and challenges that an initiative of this nature would need to address if it was to be successful in protecting the public and maintaining standards, for example:

- How would negative registration prevent barred social care workers from working in other related occupations?
- How would employers in social care be encouraged to make referrals and support the body holding the negative register through investigations and hearings?
- How would service users and the public (including carers) be supported and encouraged to make complaints and act as witnesses through investigations and hearings?

- How would care employers be prevented from employing a barred social care worker? Would it always be appropriate to do so?
- How would the negative register work with other approaches to registration and regulation of this group in other parts of the UK, and with vetting and barring schemes across the UK? Would it be clear under what circumstances an individual would be barred by the negative register and also by a vetting and barring scheme or barred by one but not the other?

5.5 The costs associated with establishing and running a negative register would need to be ascertained. A large proportion of the costs associated with statutory health and care professional regulation are in fitness to practise proceedings. We would anticipate that these would be similar for a negative register as all complaints would need to be received, screened, investigated, heard and, if necessary appealed, within a framework that was lawful and compliant with human rights. The costs of running the negative register would not be borne by the occupational group as is the case with assured voluntary registers and most statutory professional regulation. The cost of the negative register would fall on employers and tax payers.

5.6 These issues would need to be addressed if a negative register approach was to succeed in Wales. It may be that a different model is more appropriate to manage the public protection issues presented by this occupational group, such as an employer-led model.

6. Reforming the Care Council for Wales (Questions 33 to 34)

6.1 We do not support the plans in Chapter 6 about reforming the Care Council for Wales into a National Institute of Care and Support/Welsh College of Social Work and Social Care with responsibility for not only workforce regulation but also the numerous social services and workforce improvement and information functions listed in paragraph 111.

6.2 In our view creating an organisation with this combination of functions would be a retrograde step counter to modern thinking on effective and efficient professional regulation. It would not serve the public interest because perceived or actual conflicts of interest would arise which would undermine public confidence in the workforce and its regulation. The kinds of potential conflicts include, for example, the Institute/College investigating allegations of misconduct raised about a registrant it has trained or collaborated with in a social services improvement scheme.

6.3 In reviews of the General Social Care Council and the Nursing and Midwifery Council, we have discussed the importance of statutory regulators having a clear public protection purpose and focusing on that purpose.[16] The Francis Report also highlighted the risks of an organisation having blurred

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[16] CHRE, 2009. *General Social Care Council Review*, chapter 7. CHRE, 2012. *The Strategic Review of the Nursing and Midwifery Council 2012*, chapters 4 to 5. Available at http://www.professionalstandards.org.uk/library/document-detail?id=83829d41-0064-4687-9e12-43e2a556e30f and http://www.professionalstandards.org.uk/library/document-detail?id=330a9ac9-16aa-46a5-b628-cc6bb008a339 respectively.

responsibilities and purposes.[17] We consider that statutory regulation should be kept separate from professional development.

6.4 However combining system and workforce regulation within one organisation works effectively in some European countries, for example, Denmark. The Welsh Government may want to explore this option. Merging the workforce and service regulator may, in the long run, achieve cost savings that could be redirected towards supporting other organisations to deliver the non-regulatory functions included in paragraph 111. For example social care providers, training providers, the National Institute for Health and Care Excellence and the College of Social Work.

7. Service regulation and inspection

Outcomes-based service regulation and inspection (Questions 1 to 2)

7.1 We support the government's commitment to introducing an outcome-based approach to service regulation. Being outcome focused is an important element of the Right-touch regulation described above.

7.2 We suggest the government avoids referring to an organisation's fitness to practise (as happens in paragraph 63). In our view the term fitness to practise should be reserved for individual professionals. Perhaps the phrases 'fitness for purpose' or 'fitness to provide social care services' could be used instead.

Involving citizens in service regulation and inspection (Questions 5 to 8)

7.3 We welcome the government's commitment to increasing citizen involvement in the regulation and inspection of care and support services. We have published a report which looks at how regulators can effectively engage with the public.[18] The Welsh government and other agencies may find this useful.

7.4 The views of staff and professionals are also valuable – they are crucial not only for reporting things that have gone wrong, but also for highlighting areas of potential risk and on the practicability of the regulators' recommendations. But they need to feel confident that they can speak to the regulator without adverse repercussions for themselves. The service regulator therefore has a responsibility to ensure that employers support and encourage people to raise concerns and blow the whistle.

Fit and proper person (Question 13)

7.5 Paragraph 72 invites views on how the service regulator may satisfy itself that a service provider's 'responsible individual' is a fit and proper person to hold such an important role, and that they occupy an appropriately senior position within the organisation. The Authority has published a number of reports which the Welsh government may find helpful in this regard. Namely:

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[17] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC* 2013. Available at http://www.midstaffspublicinquiry.com/report

[18] CHRE, 2011. *Patient and public participation in health professional regulation.* Available at http://www.professionalstandards.org.uk/library/document-detail?id=d57becc8-a66a-4070-8d74-9710f0f81916

- *Fit and Proper? Governance in the public interest*[19]
- *Good practice in making council member and chair appointments to regulatory bodies*[20]
- Our recently updated *Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England*[21] and the report of the consultation and research we undertook to develop these[22].

8. Further information

8.1 Please do not hesitate to contact us if you would like to discuss any aspect of this response in further detail. You can contact us at:

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[19] Professional Standards Authority, 2013. Available at http://www.professionalstandards.org.uk/library/document-detail?id=d53298ac-3d5d-45cf-85fe-5004132741e0
[20] Professional Standards Authority , 2012. Available at http://www.professionalstandards.org.uk/library/document-detail?id=16cb2594-554c-4e9a-8666-70a17672dcee
[21] Professional Standards Authority , 2013. Available at http://www.professionalstandards.org.uk/library/document-detail?id=337f579e-2ce2-6f4b-9ceb-ff0000b2236b
[22] CHRE, 2012. *Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England - Advice to the Secretary of State for Health*. Available at http://www.professionalstandards.org.uk/library/document-detail?id=89114436-21e2-47df-b5a0-7d5308b66b8e