



# Enabling Excellence

## Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers

Presented to Parliament  
by the Secretary of State for Health  
by Command of Her Majesty

February 2011

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## Foreword

The Coalition Government shares the country's trust in those who work in health and social care. Their professionalism, skills, values and commitment are the critical underpinning for safe, effective and respectful care in our health and social services. In England, as the NHS White Paper, 'Equity and Excellence'<sup>1</sup> puts improved outcomes for service users at the heart of what the NHS does, it is essential that the regulatory arrangements for health professionals continue to support that objective. The current system of professional regulation helps to ensure this by setting high standards of education, training, conduct and ethics and by taking action to remove unsuitable workers in the rare cases when things go wrong. Regulation of healthcare workers and social workers therefore makes an important contribution to safeguarding the public, including vulnerable children and adults.

The Health and Social Care Act 2008 initiated a series of reforms to the governance of the health professions regulatory bodies which received cross-party support at the time. These reforms delivered a fundamental change in the governance of the regulatory bodies ending professional control over their governing councils and strengthening the contribution of lay members.

Delivering safe and effective care will continue to be the driving principle behind professional regulation. Further, in the context of "any willing provider" being able to provide services to the NHS in England, the role of professional regulation, providing a set of standards which apply to all aspects of a health or social care professional's work, whether within the NHS, a local authority, or in a self-employed setting, will become all the more important in future, in most sectors of care.

However, the regulatory framework is also complex, expensive and requires continuous Government intervention to keep it up to date. More generally, reducing regulation is a key priority for the Coalition Government. By freeing society from unnecessary laws, the Government aims to create a better balance of responsibilities between the state, business, civil society and individuals, and to encourage people to take greater personal responsibility for their actions. The Government therefore believes that the approach to professional regulation must be proportionate and effective, imposing the least cost and complexity consistent with securing safety and confidence for patients, service users, carers and the wider public. The current economic climate makes it all the more important to ensure that there are no unnecessary costs in the professional regulation system.

This Command Paper therefore sets out our proposals for how the system for regulating healthcare workers across the UK and social workers in England should be reformed to sustain and develop the high professional standards of those practitioners and to continue to assure the safety of those using services and the rest of the public. 'Reducing Regulation Made Simple'<sup>2</sup> sets out the wider Coalition Government commitment to reducing regulation to encourage sustainable economic growth and increase personal freedom and fairness. The reforms set out in this Command Paper will therefore give greater independence to those who work in health care across the UK and social care in England, to their employers, and to the health professions regulatory bodies, balanced by more effective accountability for how

they exercise that freedom. In doing so they will also provide more effective assurance of the quality of unregulated staff.

The vast majority of healthcare workers, social workers and social care workers do not strive to provide excellent care because they fear regulatory action if they do wrong or because they are told to do things properly. They do so because they are caring people, who are well trained and well motivated. They do so because they work in teams with people who share those characteristics. They do so because the organisations they work in are well led, in touch with professional values, and driven by a commitment to the individuals, families and communities that they serve.

Effective regulation of healthcare workers and social workers can support and develop the notion of professionalism by promoting self-regulation at an individual level. In the rare and troubling circumstances when things do go wrong, the regulators can take action to prevent or reduce the likelihood of instances of misconduct, or indeed incompetence, from being repeated.

However, it does not follow inevitably that compulsory and centralised statutory regulation is the most effective or efficient way of ensuring high quality care. There is a wider system for ensuring that there are adequate public safeguards in place in the health and social care sectors. For example, in England most providers are subject to regulation by the Care Quality Commission or Ofsted and most workers are covered by the Vetting and Barring Scheme, which provides for the removal from the sector of workers who may pose a risk to people in vulnerable situations.

Centralising responsibility for the complexity of managing the risk of millions of daily interactions between staff and those using services may provide an apparently neat and tidy central solution. It can never realistically supplant the individual, team and organisational commitment, harnessed to local people and local communities. This is what drives the routine and day-to-day excellence to which good professionals and good organisations are dedicated. In a society that trusts and values its health and social care workforce, obliging more of them to pay for regulation should be a matter of last resort.

Every day millions of health and care decisions are made by people themselves and an increasing number of people are taking direct control over how their support needs are met through personal budgets and direct payments in social care. Over time, with the focus on individuals having greater choice and control over decisions about their health and wellbeing, people will make even more decisions for themselves with support, where needed, from appropriately trained healthcare workers, social workers and social care workers. In a system that is truly responsive to local people, the way we assure the quality of healthcare workers, social workers and social care workers needs to be flexible enough to adapt to changes in the way people relate to health and social care services and to different local circumstances and to enable innovation and improve productivity. The Government's role is to establish a system which enables local commissioners and employers, serving local people, to ensure the most effective local systems for ensuring excellent care. That means that more responsibility and accountability is placed locally.

The proposals in this document move power away from the centre and place trust in local people, the professions that serve them and the good local leadership which enables excellent

care, whilst sustaining effective national safeguards where that is necessary. At a national level, this paper also seeks to constrain the growth and costs of the regulatory system at a time when health and social care professionals are facing pay constraints and sets out new alternatives to statutory regulation which enable both the public and employers to use a wider range of more proportionate approaches to ensure good care. It also sets out proposals to simplify the regulatory structure in order to deliver a more flexible system offering better value for money for both registrants and the public.

Although health professions regulation is devolved to Northern Ireland and, in respect of some professions, to Scotland, our system of health professions regulation is currently delivered (with the exception of pharmacy in Northern Ireland) through a UK-wide regulatory machinery. In social care, regulation of the social care workforce is devolved to Northern Ireland, Scotland and Wales. The Coalition Government recognises the need for the system for regulating healthcare workers and social workers to continue to be sensitive to the needs of practitioners and those using their services in all four parts of the UK.

Detailed proposals are being actively discussed with the administrations in Northern Ireland, Scotland and Wales in view of devolved elements with a view to reaching four country support for all aspects of the proposals. Ministers in all four parts of the UK remain committed to a UK-wide approach to regulation of the healthcare professions.

Given that social work and social care regulation is and will remain a fully devolved matter, this paper makes no reference to reform of social worker regulation or social care worker regulation in Northern Ireland, Scotland, or Wales. All references in this paper to social work regulation and to regulation of the social care workforce should be read as referring to regulation of those parts of the workforce in England only.

A handwritten signature in black ink, appearing to read 'Andrew Lansley', written in a cursive style.

Secretary of State for Health

## 1. Introduction

- 1.1 Thirty different health professions are currently regulated in law on a UK-wide basis by nine regulatory bodies<sup>3</sup> and regulation of pharmacy technicians will also become mandatory from July 2011. In addition social workers and social work students are separately regulated in all four parts of the UK by the four care councils. The regulation of healthcare professionals and social workers is delivered through bodies which have a statutory duty to protect the public by:
- setting standards of education and training for the professions that they regulate;
  - maintaining a register of those who demonstrate they meet these standards;
  - setting standards of conduct, ethics and competence required to remain on the register;
  - investigating concerns about professionals who are registered and taking appropriate action where individuals might present a risk to the public; and
  - taking action against those falsely claiming to be a registered professional.
- 1.2 The current system of professional regulation brings important safeguards to users of health and social care services. Public confidence in health and social care professionals is in part underpinned by a system which sets high standards, ensures high quality education and training, controls entry into the professions, promotes and enforces codes of conduct and ethics which help to foster, develop and sustain professional values and individual accountability.
- 1.3 The Council for Healthcare Regulatory Excellence (CHRE) acts as the independent voice for patients, service users and the public in the health professions regulatory system, providing policy advice and conducting annual performance reviews of the health professions regulatory bodies. Its most recent report<sup>4</sup> in July 2010 found that overall the health professions regulatory bodies had made good progress in recent years and were generally performing their functions well, although we recognise that there is still scope for improvement in some areas.

### **Box 1: The UK Professional Regulatory Bodies**

**Care Council for Wales**

**General Chiropractic Council**

**General Dental Council**

**General Medical Council**

**General Optical Council**

**General Osteopathic Council**

**General Pharmaceutical Council (GB only)**

**General Social Care Council (England only)**

**Health Professions Council**

**Northern Ireland Social Care Council**

**Nursing and Midwifery Council**

**Pharmaceutical Society of Northern Ireland**

**Scottish Social Services Council**

- 1.4 So while the current system is working reasonably well, and while regulation sometimes is the only way to mitigate against risk, there are nonetheless significant costs associated with statutory professional regulation. The annual reports published by the health professions regulatory bodies, by the General Social Care Council (GSCC) and the CHRE demonstrate that the total expenditure on healthcare professions regulation and the regulation of social workers in England is more than £200 million per year (see Annex A) with the operating costs of the health professions regulators met through fees paid by professionals themselves. In addition to the direct costs, regulation imposes other indirect burdens. Regulation can impose constraints on the ability of employers and professionals to respond flexibly to the changing needs of service users and the public needs or to deploy staff in a way that better suits different local contexts. While it is sometimes necessary to do so for public protection, there is a tension between enshrining professional roles in law and maximising flexibility within the workforce as a whole.
- 1.5 There may also be duplication of effort from local systems of management and clinical governance and regulatory oversight, which carries a risk of confusion about who is responsible for addressing concerns about poor practice. An over-reliance on a centralised national system of regulation can weaken local responsibility for managing problems effectively and promptly. The right balance needs to be achieved between national regulation and effective local governance and scrutiny.
- 1.6 Given these costs, it is important that any review of policy on regulation takes close account of the Hampton principles of better regulation<sup>5</sup>. While the overriding objective of the professional regulatory system should be about delivering safe and effective care, any system of regulation needs to be:
- **proportionate** to the risk that it seeks to mitigate;
  - **accountable** to ensure that all those with an interest are able to influence it;
  - **consistent**, so that it does not unreasonably place a heavier burden on any particular sector;
  - **transparent** so that its activities can be scrutinised effectively; and
  - **targeted** to avoid blanket approaches which impose regulatory burdens unnecessarily.
- 1.7 A number of new challenges that face the United Kingdom's health system and the social care system in England mean that these principles are now all the more important. The Coalition Agreement made clear that the Government will subject all regulation to much closer scrutiny, reducing unnecessary costs to both public and private sector organisations. We estimate that some 28% of regulated health and social care professionals, for whom data is available, work in the private sector<sup>6</sup> (many in a self-employed capacity), but it is critical for everyone that the costs of providing high quality care are not unnecessarily increased. While regulation of some parts of the health and social care workforce is essential to ensure public safety and to safeguard vulnerable people, the difficult public spending environment means that it is vital that regulation does not make roles any more costly than they need to be, while at the same time providing adequate assurance for service users and the public. At a time of pay restraint in both the public and private sectors, the burden of fees on individual registrants needs to be minimised.



- 1.8 In addition, the Coalition Agreement signalled an end to the assumption that national statutory action should be the first resort in dealing with risks arising from professional activities or concerns that happen locally. It is not necessarily the case that the state should automatically take responsibility for managing risks which arise from the activities of healthcare workers, social workers and social care workers, or assume that national legislation is the most effective vehicle for doing so. The health and social care systems in the United Kingdom therefore need a new approach to risk that is more effective and more responsive to local and individual needs. Whilst the current system for regulating healthcare workers and social workers does provide an important safeguard, there are limitations on its effectiveness, because it is too distant from where risk occurs to enable it to act proactively and preventively in all circumstances.
- 1.9 The case for a more balanced approach to regulation of healthcare workers has been made by the CHRE in its publication ‘Right-touch regulation’<sup>7</sup>, which makes the case that although regulation has an important public role, it should exist to protect people, not to control unduly how they choose to live their lives. Right-touch regulation recognises that there is usually more than one way to solve a problem and that regulation is not always the best answer. In applying the principles of good regulation, we should always seek to use the minimum regulatory force required to achieve the desired result.
- 1.10 The Coalition Government believes that whilst statutory regulation of the health and social care workforce plays a key role in ensuring clear standards for professions as a whole, by assuring the quality of education and setting standards for entry to and continuing registration in a profession. However, the risks posed by individual failings are often most effectively and quickly mitigated by timely local action and effective leadership by senior health and social care professionals.
- 1.11 The General Medical Council (GMC) has described how there should be a “four layer model of regulation”<sup>8</sup> for practitioners who work in an employed environment as part of wider clinical teams:
- i. The most effective protection against poor practice is the individual practitioner. Their own values, supported by their professional ethos, should be what most effectively ensures good care for every person that they care for.
  - ii. Next, their peers and colleagues should provide assurance, with everyone working together to ensure that each other’s care is safe, effective and respectful.
  - iii. That culture of care in the team should in turn be embedded and sustained by effective leadership, management and clinical governance in the organisation that provides, or arranges the provision of, care.
  - iv. Finally, the professional regulatory bodies and the bodies that regulate the providers of health and social care services provide a national framework of assurance.
- 1.12 We recognise that there are limitations to the model of assurance described above for some groups of workers and, particularly for self-employed practitioners, there may be no team or employer present. Indeed, people using personal budgets or direct payments to meet their support needs may actually be the employers of those providing them with services. In a limited number of cases therefore, statutory regulation may be the only

way of effectively mitigating against risks to people using services, although it would need first to be clear that assured voluntary registration would be insufficient to help guide choices by commissioners and patients. However, for the majority of health and social care workers who do work as part of wider clinical teams, either as an employee or contractor, it is applicable.

- 1.13 Social workers work in a different context to healthcare workers, but this model is still broadly applicable, with supervision, multi-disciplinary case conferences and peer scrutiny playing an important role in ensuring high quality care. It is noticeable that major systemic failures in both the health and social care sectors are often characterised by insufficient attention paid to professional standards within teams and by employing/ commissioning organisations, a lack of support for staff and a weak professional voice in management decisions.
- 1.14 Increasingly therefore, we need to ensure that, for staff in direct employment, employers providing or arranging health and social care services take clear responsibility for supporting, developing and managing teams and individuals to strengthen and foster professional excellence, relying on regulatory action only when local remedial action has failed or is not possible. By focussing responsibility for excellent care closest to where that care takes place, it is more likely that any issues can be identified early before they become serious problems, and there will be much clearer local accountability for the safety and quality of care. We recognise that the role of the national regulators in supporting local employers is an important one and it will become all the more so in a system where there is greater responsibility devolved to employers.
- 1.15 For groups of staff that are currently unregulated, the first response will not be to impose national compulsory regulation, but to enable employers to take local responsibility for the quality of the staff that they employ and to give a stronger voice to individual workers to speak up when they have concerns.

## 2. Reducing the Costs of Regulation

- 2.1 At their current planned level of expenditure, the combined cost of the health professions regulatory bodies and the GSCC exceeds £200 million a year<sup>9</sup>. The direct costs of the system fall largely on registrants themselves, through the annual retention fees that they pay for their registration. However, as these fees are partially tax deductible, and also feed into pressure on pay in the NHS, there is also a significant cost to the taxpayer. There are also indirect costs associated with the professional regulatory system, such as the costs to employers where staff are suspended pending the outcome of a complaint made to a regulatory body.
- 2.2 Fees vary significantly between different regulators. While the model of regulation applied by different regulatory bodies varies, this disparity in costs can largely be attributed to economies of scale. Regulators with large volumes of registrants, such as the Health Professions Council (HPC) and the Nursing and Midwifery Council (NMC) are able to spread the costs of core infrastructure across a larger number of people, whereas registrants of smaller bodies such as the General Chiropractic Council (GCC) and General Osteopathic Council (GOsC) share a larger proportion of these costs (see Annex A).
- 2.3 However, scale is not the only factor. Some regulators have leaner and more businesslike approaches to aspects of their work. Some make greater use of legal advice in their fitness to practise proceedings, while others utilise more innovative approaches to fitness to practise (including a greater range of sanctions). These variations partly reflect the different legal frameworks for each of the regulators, but there is likely to be scope for significantly greater efficiency in all the regulatory bodies.
- 2.4 A key driver of costs in the sector is the investigation of complaints or concerns about practitioners and taking appropriate action on their registration (see box 2). The 2010 CHRE Annual Report noted the continued rising trend in the number of complaints/concerns that regulators are receiving and investigating. Without concerted action to contain costs, there will be an increasing burden on registrants and taxpayers for assuring professional standards at a time when employers are under pressure to restrain pay.
- 2.5 The simplest means of reducing the costs of regulation would be to merge regulators into higher volume organisations. The Coalition Government has recently announced the transfer of the GSCC's functions to the HPC in order to achieve a strong,

### Box 2: Fitness to Practise Costs

While the proportion of expenditure on fitness to practise varies considerably across the regulatory bodies, 'Safeguarding your health and wellbeing: The NMC's annual report and accounts for 2009-2010' demonstrates that the Council's expenditure on fitness to practise (investigation of complaints and taking action against nurses, midwives and health visitors for breaches of its professional standards) amounted to £19.7 million out of a total expenditure of £36.7 million. This amounted to around 54% of the NMC's entire expenditure over the year.

independent and sustainable system of regulation for social workers in England, and proposals to achieve reforms to the GMC's adjudication functions without establishing the Office of the Healthcare Professions Adjudicator (OHPA) as an operational entity. Both of these measures will reduce the projected costs of regulation.

- 2.6 We recognise however, the disruption and professional concern that centrally imposed consolidation can cause. As an alternative to further structural change, we will commission the CHRE to lead a sector wide review of the cost-efficiency and effectiveness of each regulator within the CHRE's remit, with a view to identifying significant costs savings. We anticipate that this review will draw on learning from the review of the Department of Health's arms length bodies' back office functions. Given the need for pay restraint amongst the health and social care professions, the Government would not expect registration fees to increase beyond their current levels, unless there is a clear and robust business case that any increase is essential to ensure the exercise of statutory duties. We welcome the move by the GMC to lower the fees for trainee doctors completing specialty training in 2010/11 and its intention to cut fees for newly qualified doctors and those doctors on the lowest incomes from 1 April 2011.
- 2.7 Should any regulators wish to propose mergers with other regulatory bodies to reduce costs as part of this work, the Government will view these proposals sympathetically. If the sector itself is unable to identify and secure significant cost reductions over the next three years, and contain registration fees, then the Government will revisit the issue of consolidating the sector into a more cost-effective configuration. We would also encourage the health professions regulators to explore whether there are any other areas across the regulatory system where there is currently unnecessary duplication with the roles of other bodies, such as the system regulators, or those involved in the quality assurance of education.
- 2.8 In that context, the Government will not support the health professions regulators in taking on any new responsibilities or roles which add to the costs to their existing registrants without providing robust evidence of significant additional protection or benefits to the public. As the new accountability and scrutiny arrangements set out below are introduced, the health professions regulators will need to demonstrate that measures such as advanced practice registers, which have some professional support but where a compelling case for further regulatory action has yet to be made, are an appropriate and proportionate use of registrants' fees.

### 3. Independence and Accountability

- 3.1 The 2008 reforms to the health professions regulators, supported by all sides in Parliament, made important changes to the governance of the regulatory bodies through the make up of their councils by strengthening the contribution of lay members. By ending elected professional majorities on the health professions regulatory bodies' governing councils, this increased the independence of the regulators from those they regulate and sign-posted a commitment to ensuring that there is greater public, professional and parliamentary confidence in the regulators and reducing perceptions that they are either acting in the interests of the professions they regulate or acting overly punitively to counteract this view. There is also evidence that the health professions regulators' performance of their statutory duties has improved. For example, in 2009/10, of the 1,835 final fitness to practise decisions reviewed by the CHRE to ensure that concerns had been properly dealt with, only 2 of these (0.1%) required a referral to the High Court for undue leniency. This compares favourably with the situation in 2004/05 when of the 590 final fitness to practise decisions reviewed by the CHRE, 8 of these (1.4%) required a referral to the High Court for undue leniency<sup>10</sup>.
- 3.2 Whilst these reforms have clearly had a beneficial impact, there are two important unresolved issues. First, the ending of the practice of most council members being elected by registrants may have reduced the amount of scrutiny over regulatory bodies by the professions themselves. In law, the health professions regulators, other than those for pharmacy professions (see below), are accountable to Parliament, through the Privy Council, for the exercise of their statutory duties. Each regulator is required to present to Parliament an annual report on the conduct of their business and on the efficiency and effectiveness of their fitness to practise arrangements, and the CHRE conducts a thorough annual performance review of the regulators. However, the suggestion has been made that, given the considerable responsibilities that the regulators have for assuring patient and public safety, even more parliamentary scrutiny would be desirable<sup>11</sup>.
- 3.3 In the case of the General Pharmaceutical Council (GPhC), similar accountability arrangements apply, although the council is also accountable to the Scottish Parliament and the Pharmaceutical Society of Northern Ireland (PSNI) is accountable to the Department of Health, Social Services and Public Safety Northern Ireland. As they regulate professions regulated since devolution, the General Dental Council (GDC) as well as the HPC must present their annual reports and strategic plans to the Scottish Parliament. CHRE also has certain accountability to the Scottish Parliament.
- 3.4 At the same time, whilst the regulators have secured independence from the professions that they regulate, they remain dependent on Government and Parliament for legislation which enables them to modernise their organisations to ensure that they are meeting their duties to protect the public in the most cost-efficient and effective way. Until the 2008 reforms, there continued to be a degree of concern that professional interests might influence the policies and actions of the regulators. As a result, their freedom to act is constrained through a complex web of legislation dating back to 1858, covering

numerous Acts of Parliament and Orders over the period, often prescribing procedures of the regulatory bodies in great detail. Government and Parliament are therefore continually obliged to update their legislative framework to enable the regulators to adapt to changing circumstances and effectively fulfil their statutory obligations to protect the public.

- 3.5 The constraints on Government resources mean that only the most pressing issues are acted upon and the process for making these changes takes about two years. Consequently, regulators are frequently unable to make important changes that would allow them to improve their performance, work less bureaucratically, reduce costs to registrants and respond more fairly and effectively to both public and professional concerns. The current legislative framework over-regulates the regulators themselves by constraining their freedom to adapt and modernise.
- 3.6 To address these concerns, the Coalition Government has commissioned a simplification review of the legislative framework for professional regulation, with a view to giving greater autonomy to the regulatory bodies to decide how best to meet their statutory duties. In light of this, it would be our intention to seek Parliament's agreement to create an enabling legislative framework for the regulatory bodies, through a single Act of Parliament, to reduce the number of complex pieces of legislation. Whilst Parliament would continue to set in statute a high level legislative framework to provide the powers and duties of the professional regulatory bodies and the outcomes required from them, it would be for the regulators themselves to decide on, and take responsibility for, how these outcomes were delivered in practice and for ensuring that they were compatible with human rights and other legislation.
- 3.7 Under these arrangements, the regulators would have statutory duties both to inform the public of their functions and to consult on the way they delivered them. The Privy Council would retain a power of last resort to intervene if a regulator were failing to meet its statutory duties and Parliament would retain oversight of any proposals to extend regulation and protection of title to unregulated occupational groups, or to deregulate currently regulated groups of staff. The Government has asked the Law Commission to undertake a simplification review of the existing legislative framework and to develop a draft Bill for consultation. This will be a substantial body of work which will take some time to complete, but the intention would be to introduce legislation towards the end of the current Parliament.
- 3.8 These proposed measures to increase the autonomy of the regulatory bodies in the exercise of their statutory functions will need to be balanced by a commensurate strengthening of their public and parliamentary accountability for their performance. The Government will discuss with the Parliamentary authorities what formal mechanisms might be established to enable Parliament to hold the regulators to account. We will explore the scope for an increased role for the CHRE, which will become self-funded and therefore independent of Government by April 2012, in enabling greater scrutiny by Westminster and the Devolved Administrations through its annual performance review process. In order to avoid the Parliaments and Assemblies scrutinising directly the quasi-judicial functions of the regulators in individual cases, such matters would continue to be subject to the relevant courts across the UK.



- 3.9 In line with the commitments made in ‘Reducing Regulation Made Simple’<sup>12</sup> we will consider in light of the Law Commission’s recommendations whether sunset clauses should be introduced in respect of parts of the legislative framework for health and social care professionals. This would ensure that, in future, regulations are subject to periodic review to ensure that they remain fit for purpose.
- 3.10 There also needs to be greater accountability for any failure of regulators to undertake their functions as competent authorities under European Law, for the purposes of mutual recognition of professional qualifications. Under the current arrangements, the UK taxpayer is liable for any fines resulting from any regulatory failure to comply with EU legislation. The Government will explore scope for taking powers to seek a contribution towards any such fines from the regulatory bodies themselves with a view to legislating at the earliest opportunity.
- 3.11 Additionally, there is a need to strengthen the accountability of the regulatory bodies to those using the services of their registrants and the wider public, by creating a route to raise concerns about the policies and approach of the regulators with the CHRE about those bodies falling within its remit. We plan to do this by commencing Section 28 of the National Health Service Reform and Health Care Professions Act 2002, which provides the CHRE with certain powers in respect of the investigation of complaints made to it about the way in which a regulatory body has exercised any of its functions. Its’ role would be restricted to considering regulatory bodies’ administrative and policy matters, to avoid the CHRE, which currently has fewer than 20 staff, from being overwhelmed by complaints from individuals who simply disagree with the decisions reached by the regulators.
- 3.12 Since the reforms to the health professions regulators, members of the governing councils of the regulatory bodies have been appointed by the Privy Council, based on an independent recruitment process conducted by the Appointments Commission. Under the arm’s-length body review, the Appointments Commission will be abolished by the Health and Social Care Bill, subject to Parliamentary approval, from April 2012. There is a need to retain an open, independent, competence-based system of appointment and we will discuss options for achieving this outcome over the longer term with the Devolved Administrations, the Privy Council, the regulators, the CHRE and other interested parties. In the meantime, to enable appointments to be made once the Appointments Commission is abolished, there are to be new powers in the Bill enabling the Privy Council to arrange with others, including the regulatory bodies themselves and the CHRE, for the Privy Council to be assisted in making appointments to the regulatory bodies.
- 3.13 As with the health professions regulators themselves, appointments to the CHRE’s council, which are currently made by the Secretary of State for Health, will in future (subject to parliamentary approval) be made by the Privy Council, rather than by Ministers, to underline its independence from Government. While the majority of appointments to the CHRE’s council will therefore be made by the Privy Council, Ministers in the Devolved Administrations will retain their powers to make appointments to the CHRE’s council to reflect the need for policy in respect of the regulation of health professionals to meet the needs of service users in all four parts of the UK.

- 3.14 The Government believes that the system of directly appointed chairs is working well for those regulatory bodies which already have them. We will ask the CHRE to advise by the end of 2011 on whether there is a case for moving to competence-based appointments for the chairs of all regulatory bodies and ending the practice whereby some chairs are elected from amongst appointed members, and to advise on whether there is a case for moving to smaller councils as a way of delivering more board like and effective governance and constraining costs. We will also explore whether the appointment of the chairs of the regulatory bodies could be subject to some form of active scrutiny and/or approval by Parliament.
- 3.15 In line with the drive for greater efficiency and continued public confidence in their work, the Government will ask all of the health professions regulators (with the exception of PSNI which is a matter for Ministers in Northern Ireland) to review their governance arrangements, to satisfy themselves that their councils focus on strategy and the performance management of their executives, rather than on direct involvement in operational matters. Many have already moved to smaller more board like structures (the NMC for example estimates that it has saved more than £0.5 million per year through adopting a smaller, more strategic, council) and the Government expects that all the health professions regulators should adopt this approach.
- 3.16 At the same time, they should have mechanisms in place to ensure that the voices of their interest groups are properly heard and the structures they have in place are robust, but proportionate. This should include discussions about the complexity of their governance arrangements and the size and make-up of councils and committees. The Government will also ask the CHRE to report later this year on the governance arrangements of the regulators and to provide assurance that, where necessary, steps are taken to move to smaller councils which focus on strategic issues.
- 3.17 Employers, with responsibility for clinical governance and individual disciplinary matters, and commissioners with ultimate responsibility for the quality of services delivered under contract, are key players in the system and the expertise that they bring will be important to further strengthening regulatory body councils. Equally, the regulators are dependent on the cooperation of employers, providers and commissioners in managing concerns about professionals at the local level. Whilst the recent reforms of the regulatory bodies ensured a stronger voice for the public on the councils of the health professions regulatory bodies, less progress has been made in ensuring that employers and commissioners from across the UK contribute directly to the strategic leadership of the regulatory bodies. We will discuss this issue with the Devolved Administrations with a view to asking the CHRE for advice about to how to achieve this. We recognise that for some regulatory bodies, such as those regulating chiropractors and osteopaths, where their registrants predominantly work in a self-employed capacity, this would not be appropriate.
- 3.18 The review of regulation taken forward by the Law Commission will take a number of years and will then need to be considered by Parliament. Given this, the Government will consider with the Devolved Administrations, the CHRE and the regulatory bodies themselves if any immediate changes to the law are required to ensure public protection is in place and to enable any changes which require legislation to achieve cost-savings identified by the CHRE review.



## 4. Unregulated Workers

- 4.1 Regulation of the health and social care workforce is sometimes necessary where there are significant risks to people using services which cannot be mitigated in other ways. However, in recent decades compulsory blanket statutory regulation of the health and social care workforce in England has too often been seen as the first resort, rather than the last, in deciding how best to assure safe, effective and respectful care. Where regulation has been extended, there has not always been a robust and transparent case made based on the level of presenting risk. Currently, nearly 1.4 million staff, in 31<sup>13</sup> professional and occupational groups (which are regulated through enactments of the Westminster Parliament) are regulated in this way. If regulation of this type were to continue to be extended to all groups where the previous administration had made commitments to introduce regulation, an additional 1.3 million workers<sup>14</sup> (many of whom are in relatively low paid support roles) would be obliged by law to pay registration fees in order to continue to pursue their livelihoods.
- 4.2 In many cases, the risk to service users and the general public posed by groups of unregulated health and social care workers is not considered to be such that regulation of individual workers is necessary, given the wider safeguards within the system, such as the Vetting and Barring Scheme in England and Wales and the regulation of most providers of health and social care services. In general terms, the Government 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. The emphasis should be on employers of unregulated workers to take responsibility for the quality of services provided.
- 4.3 However, we recognise that a more flexible system is needed to enable employers to assure themselves that prospective employees have met adequate standards of training and competence and to enable individual members of the public who seek care directly from unregulated self-employed professionals to assure themselves about their standards. Such a system should also allow people who work in professions or occupational groups who are not regulated in law to demonstrate, if they wish to, that they meet high standards.
- 4.4 To this end, the Government proposes to enable a system of assured voluntary registration to be developed for professionals and occupational groups which are currently not subject to statutory professional regulation. At present, there are a range of voluntary registers, but no system which allows the public, employers or professionals to gauge whether they operate effectively and to high, or common, standards. A system of assured voluntary registration is a more proportionate way of balancing the desire to drive up the quality of the workforce with the Coalition Government's intention to avoid introducing regulation with its associated costs wherever possible.
- 4.5 The Government intends to establish the CHRE as the national accrediting body for health professionals UK-wide who are currently not regulated by statute, healthcare workers UK-wide and social care workers in England, as well as certain students and social care

professionals in England. The CHRE will set standards against which the governance, procedures, registration criteria and performance of voluntary registers can be judged to establish whether they are sufficient to provide assurance to the public and employers about the training, skills and conduct of their registrants. The existing statutory regulatory bodies already have significant expertise in establishing and raising professional standards which could be used to support the development of other professional and occupational groups and they will be given powers to establish voluntary registers of persons in professions, occupations or trades which undertake roles which are related to the roles of professions they currently regulate on a statutory basis. In establishing voluntary registers, we would expect the regulators to draw on tools that already exist, such as the Knowledge and Skills Framework in the NHS, where appropriate.

- 4.6 The system of voluntary registration will be funded by those joining voluntary registers and the CHRE will provide strategic oversight and responsibility for the development of a coherent and cost-effective system of registers.
- 4.7 Where existing regulators establish new voluntary registers, we would expect them to introduce more proportionate approaches to the removal of persons from these registers (for example, by permitting removals by administrative means in certain types of case, but with the right for registrants to require an internal panel hearing if they choose). We would expect existing regulators to make it clear that registrants on voluntary registers are not subject to full statutory regulation and to require registrants themselves also to make this clear to their clients/patients. In view of the fact that membership of these registers would be voluntary, the effects of removal from a list would be less severe and this difference in approach would be proportionate, provided that there were robust internal appeals mechanisms in place. Any such mechanisms would of course need to be compliant with the European Convention on Human Rights.
- 4.8 We will also ensure that any voluntary registration systems accredited by the CHRE make appropriate links to the wider regulatory system and include appropriate policies on professional indemnity and safeguarding, including, where appropriate, procedures for making referrals to the Independent Safeguarding Authority (ISA) or Disclosure Scotland, where individuals are considered to pose a risk to the public. We will ask the CHRE to draw up detailed proposals for the way that a system of voluntary assured registration would operate in practice. The CHRE will need to ensure as part of its accreditation process that voluntary registers are not misused to enforce protectionist practices by any individual professions. We also believe that voluntary registration bodies could also act as a point of contact for persons wishing to raise concerns about the poor practice of unregistered persons in England and refer them to ISA where necessary. We plan to take forward these proposals as part of the work programme that follows from the Government's review of the Vetting and Barring Scheme in England, Wales and Northern Ireland.
- 4.9 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.

- 4.10 Similarly, commissioners of services from independent contractors who are not subject to regulation could give weight to providers using staff meeting criteria required by accredited registers when awarding contracts. Individual members of the public seeking care from self-employed practitioners will be able to choose to go to practitioners on an assured voluntary register. Independent practitioners themselves will take a judgement on whether to join the register in order to attract more patients or clients. To underpin this, we will need to ensure that members of the public, including those managing their own care, have adequate and appropriate information to enable them to make informed decisions about arranging their own care with independent practitioners.
- 4.11 Rather than a single statutory approach regardless of local needs and local approaches, quality assured voluntary registration will provide greater flexibility and give the public and local employers greater control and responsibility for how they assure themselves about the quality of staff. For the overwhelming majority of occupational and professional groups which are not currently subject to statutory regulation and which are generally not considered to present a high level of risk to the public, but where recommendations that regulation should be introduced have been made (including those groups recommended by the HPC for statutory regulation in the past, but not yet registered), the assumption will be that assured voluntary registration would be the preferred option.
- 4.12 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.
- 4.13 The exception to this is practitioners of herbal medicine, including Chinese herbal medicine. Under European law, manufactured medicines placed on the market require a suitable product licence, and from April 2011 this also applies to manufactured herbal medicines. However, Member States have the power to operate national arrangements permitting appropriately authorised healthcare professionals to commission an unlicensed medicine to meet a patient's special needs and the UK already does so for doctors and certain other appropriately regulated prescribers. While there is evidence of public health risk where unlicensed herbal medicines are supplied by unskilled practitioners, the impact on practitioners and on consumer choice of preventing the supply of all such herbal medicines would be disproportionate. We therefore propose to introduce regulation for these practitioners by the HPC, to ensure that the public are able to access these products if they should choose to do so and to provide improved assurance of the competence of practitioners. The focus of regulation will be solely on minimising risk to the public.
- 4.14 The Government recognises the strong public, patient and professional concern about instances where senior managers who have let people down appear to have avoided significant consequences for their actions and that a stronger assurance mechanism is needed. Whilst the precise nature of this mechanism needs to be discussed further with employers, patients, professionals and the public, as a foundation for this, we will commission independently led work to agree consistent standards of competence and behaviour for senior NHS leaders.

## 5. Ensuring Continuing Fitness to Practise

- 5.1 The Department of Health in England remains firmly committed to supporting the GMC in implementing a proportionate and effective system of medical revalidation in England, but shares concerns expressed by employers and the profession itself that the existing proposals were overly complex and time-consuming. To that end, the Secretary of State for Health announced in June 2010 that he would extend piloting for a further year in England to allow systems to be streamlined and robust cost-benefit analysis to be carried out. Subject to a test of readiness in the summer of 2012, revalidation will be rolled out in late 2012.
- 5.2 The Responsible Officer regulations came into force on 1 January 2011. Responsible officers will play a key role in supporting doctors to improve the quality of care they provide and in ensuring that prompt action is taken to protect patients where concerns arise about the practice of individual doctors.
- 5.3 For the other regulated health professions, there is a wider spectrum of risk to be addressed by different regulators and a “one size fits all” approach would not be appropriate. For very large volume professions, it would also represent a significant cost. The Department retains an open mind on this issue. The Department, with the agreement of the Devolved Administrations as appropriate, has therefore asked each of the health professions regulatory bodies which are accountable to Westminster to continue to develop the evidence base that will inform their proposals for revalidation over the next year. For those professions where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services from additional central regulatory effort on revalidation, the Government will agree with the relevant regulators, the Devolved Administrations, employers and the relevant professions the next steps for implementation.
- 5.4 In the meantime, the key responsibility for ensuring continued high quality care will remain with employers, providers and commissioners of services, the teams who assess and provide care and with individual professionals themselves. It is there, closest to the point of care, that any risk is most effectively and most promptly addressed.
- 5.5 Whilst these arrangements provide potentially stronger assurance of the quality of those working in health and social care who are already practising, the Coalition Agreement committed the Government to ensuring that all overseas workers who come to work in the United Kingdom have the language and professional skills needed to practise safely and effectively in the United Kingdom. The Government has had constructive discussions with the European Commission, the GMC and others on these important issues and is developing proposals on how the NHS Commissioning Board in England and the regulatory bodies can develop more effective assurance systems that are consistent with the need to provide for the free movement of professionals across the European Union. We will also provide evidence to the European Commission ahead of its review of the Directive on Mutual Recognition of Professional Qualifications in 2012.

- 5.6 The Government recently consulted on proposals for an information revolution<sup>15</sup>, transforming the way information is accessed, analysed, shared and used so that people can take more control of their health and social care. Strong professional (clinical, managerial and informatics) leadership will be needed to deliver this vision and it will require most health and social care professionals to be capable and confident information managers and brokers and to have a strong understanding (and adherence to standards) of information governance. To reinforce this, the Government intends to work with the professional regulatory bodies to seek to ensure that standards of practice and proficiency and codes of professional conduct adequately reflect the demands of the information revolution.
- 5.7 When patients, the public, and service users receive substandard care from a healthcare professional, they should have available to them, or their advocates, a means to seek redress. The Coalition Government and the Devolved Administrations believe that the requirement that registrants should hold insurance or indemnity cover should be consistent across health regulation, and that introduction of any requirements should not be framed so as to require individual employees to obtain personal cover themselves when they are already covered by corporate or employer cover. Working in partnership with the Devolved Administrations, we will seek to implement greater consistency across the professions in light of the requirements of the proposed Directive on Patients' Rights in Cross-border Healthcare, once it is finalised and as and when the legislative opportunity arises.

## 6. Regulation of the Social Care Workforce

- 6.1 While the preceding chapters of this document have focused predominantly on reform of the system for regulating healthcare professionals in the UK, this chapter sets out proposals for the reform of the system for regulating social workers and other social care workers exclusively in England. Different regulatory systems for the social care workforce exist in Northern Ireland, Scotland and Wales which are unaffected by the proposals in this paper.
- 6.2 The regulatory context in social care in England is very different from that of healthcare workers. The vast majority of the workforce is unregulated<sup>16</sup> and increasing numbers of people receiving support from social services are opting to use personal budgets and direct payments to deliver support which does not rely on traditional methods of service provision and will often be delivered by unregulated workers. Social workers, as trained professionals making autonomous judgement about interventions, are subject to regulation in all parts of the UK. However, there are a range of different regulatory arrangements in place for other groups of social care workers in different parts of the UK (in Scotland, for example, the Scottish Social Services Council has 18 different parts to its register). No groups of social care workers are subject to statutory regulation in England at this time.
- 6.3 The model of regulation adopted for social workers in England differs from the model that applies to healthcare workers, in that the GSCC in England is primarily funded through general taxation, rather than through professional fees. In contrast with the arrangements for health professionals, the GSCC was established as an arm's length body of the Department of Health with accountability directly to Ministers, rather than to Parliament. The fees for social workers have been heavily subsidised by the taxpayer. Currently the costs incurred by the GSCC for the regulation of social workers works out at about £250 - £300 per year per social worker. Social workers pay £30 per year – the remainder is paid for by taxpayers.
- 6.4 An independent review of the GSCC's conduct function carried out by the CHRE in 2009<sup>17</sup> recommended that the GSCC become independent of government with its costs funded by social workers. It also recommended that the GSCC's conduct process should be amended to bring it in line with the fitness to practise regimes operated by the best health professions regulators, as complaints about the competence of social workers were rarely taken forward under the existing conduct process.
- 6.5 In 'Liberating the NHS: Report of the arm's-length bodies review'<sup>18</sup> the Government announced its intention to transfer the GSCC's regulatory functions to the HPC, which will be renamed the Health and Care Professions Council to reflect its new broader remit in England. The HPC is a UK wide body which is self-funding and the principle of independence from government will therefore also be extended to the social care sector in England. Although the HPC operates on a UK wide basis in respect of its current healthcare functions, its responsibility for the regulation of social workers will be England only in extent.



- 6.6 The transfer underlines the Government's commitment to continuing the process of strengthening the social work profession by putting it on an equal footing with other comparable professions. The transfer will ensure that, in future, the fitness to practise of social workers as a whole will be taken into consideration where concerns are raised about their standards of practice. We also propose to extend the remit of the CHRE to cover social worker regulation in England, as well as health profession regulation across the UK. This will ensure consistent scrutiny over the regulatory arrangements for both sectors in England and to enable the CHRE to refer to court fitness to practise cases where it considers that the sanction the regulator has imposed to be unduly lenient. The CHRE will be renamed as the 'Professional Standards Authority for Health and Social Care' to reflect its broader role.
- 6.7 The Government is clear that there is a need to retain a strong professional identity for social workers following the transfer of responsibility for regulating social workers to the HPC. We envisage that the proposed College of Social Work, which has already been established in shadow form and is expected to be operational by Spring 2011, will be the means to achieve this. As a professional body, it will have an important role to play in providing a national voice for the profession in England.
- 6.8 The Social Work Reform Board is currently considering the case for a licence to practise for social workers in England and the introduction of an assessed year in employment for newly qualified social workers, in line with the recommendations of the Social Work Task Force. The Government is keen to explore these issues further and once there are some firm proposals we will need to consider the evidence base as well as the costs and benefits, particularly if there are proposals for regulatory change.
- 6.9 We have previously made the point that an over-reliance on a centralised national system of regulation can weaken local responsibility for managing problems effectively and promptly. This is equally the case in the social care sector, where 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. Under the previous administration, commitments were made at various times to regulate the entire social care workforce and 412,000 home care workers in particular<sup>19</sup>. However, these commitments were not met in practice.
- 6.10 In line with the Coalition Agreement, we are committed to reducing unnecessary costs of regulation and in the current difficult public spending environment we do not believe that the statutory regulation of home care workers, or the wider adult social care workforce can be justified. It is already the case that many providers of adult social care services in England must register with the Care Quality Commission (CQC) and meet a set of 16 requirements of essential safety and quality. These include requirements for providers to ensure that all staff are fit for the job, have the right qualifications, skills and experience and that they are properly trained, supervised and appraised. It is also the case that most people working in adult social care in England fall within the scope of the Vetting and Barring Scheme. The Government is not convinced that the case has been made for subjecting low paid workers in the adult social care sector to an additional tier of regulation by regulating individual workers.

- 6.11 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.
- 6.12 A significant body of workers in the care home sector, in particular, may work across both local authority and NHS funded organisations. It is therefore our view that common standards should underpin the regulation of healthcare support workers and adult social care workers in England (we recognise that social care workers in children's services work in a somewhat different context and common standards may not therefore be applicable).
- 6.13 There are various ways in which common standards for healthcare support workers and adult social care workers could be achieved. We note the employer led approach that has been adopted for healthcare support workers in Scotland and which could be replicated elsewhere. Alternatives include, for example, establishing a single voluntary register of all healthcare support workers and those social care workers providing services to adults in England<sup>20</sup>, or for there to be separate registers for different groups of support workers held by different bodies, but operating to commonly agreed standards. It is also possible that a single jointly administered register could be established, although this possibility would need to be explored in more detail. To encourage open debate by all interested parties, the Government will discuss the issue with the Devolved Administrations with a view to asking the CHRE to consult on this issue as part of their implementation arrangements for voluntary registers.



## 7. Next Steps

- 7.1 A new 'Enabling Excellence through Professional Standards' Programme will be established by the Department of Health to implement the policy proposals in this paper.
- 7.2 As a first step in implementing this paper we will, subject to Parliamentary approval, reform the CHRE to make it self funding, provide it with a remit in respect of the social care workforce in England and provide it with the powers needed to establish a system of assured voluntary registration in the Health and Social Care Bill 2011. The CHRE will be given the powers to become the national accrediting body of voluntary registers and to establish a cost-effective and coherent system. Also in the Health and Social Care Bill 2011, we will abolish the OHPA and the GSCC and transfer responsibility for regulating social workers in England to the HPC by April 2012. By this time, the new College of Social Work will be operational and will have taken on a key role in promoting the professional interests of social workers in England.
- 7.3 We will discuss with the Devolved Administrations our intention to ask the CHRE (subject to the necessary powers for it to do so being approved in the Health and Social Care Bill 2011) to provide UK health Ministers with advice on the issue of assured voluntary registration. This will include seeking advice on options for establishing voluntary registers for healthcare support workers across the UK and social care workers working with adults in England, taking account of the review of the Vetting and Barring Scheme and other developments in the wider regulatory system and a process for setting standards for these workers, as appropriate. We will ask the CHRE to ensure that its advice on this issue takes account of the views of health and social care professionals, their employers, the health and social care professions regulators, people who use services and the wider public.
- 7.4 We will discuss with the Devolved Administrations with a view to jointly consulting on proposals to implement a register of persons authorised to dispense unlicensed herbal medicines, with a view to enabling the continued supply of herbal medicinal products to the UK population, in 2011.
- 7.5 We will also ask the CHRE to provide UK health Ministers with advice about scope for delivering efficiency savings across the health regulatory bodies by the end of 2011 and with advice on detailed proposals for commencing Section 28 of the NHS Reform and Health Care Professions Act 2002 to create a mechanism whereby individuals have a route to raise concerns about the policies of the regulatory bodies by the end of 2011.
- 7.6 We will discuss by the end of 2011 with the Parliamentary authorities and the CHRE what formal mechanisms might be established to enable the Parliaments and Assemblies to hold the regulators to account.
- 7.7 Throughout 2011, we will work with the Department for Business Innovation and Skills to provide evidence to the European Commission about the operation of the Directive on Mutual Recognition of Professional Qualifications ahead of a review of the Directive

by the Commission in 2012. The Government firmly believes that doctors and other health and social care professionals should be able to communicate effectively with those using services. We will continue to work up proposals for the planned NHS Commissioning Board in England to oversee a more effective system for undertaking checks on language knowledge of primary care practitioners to address the historic lack of consistency in the application of checks by primary care trusts.

- 7.8 The Department will explore scope for taking powers to enable it to seek a contribution towards any fines arising from infractions that have been caused by failings on the part of the regulatory bodies, including through new powers proposed in the Localities Bill during 2011.
- 7.9 Also in 2011, we will ask the CHRE for advice about how to ensure an effective and transparent mechanism for making appointments to the UK health professions regulatory bodies' councils, including to the body charged with the regulation of social workers in England, over the longer term, once the Appointments Commission is abolished. As part of this work, we will discuss with the Devolved Administrations with a view to asking the CHRE for advice about whether there is a case for moving to competence-based appointments for the chairs of regulatory bodies. Alongside the CHRE's work, the Department and the Devolved Administrations will explore whether the appointment of chairs could be subject to some form of active scrutiny and/or approval by Parliament.
- 7.10 The Law Commission will begin its review of the existing legislative framework for professional regulation in 2011 and will report in 2014 with new legislative proposals on which to consult before the end of the current Parliament.
- 7.11 We remain committed to the implementation of medical revalidation, and will work collaboratively with the Devolved Administrations to ensure it is delivered coherently across the UK. The Secretary of State's announcement to extend the pilots provides a greater opportunity to test further the components of revalidation. In doing so, we will develop a clear understanding of costs, benefits and practicalities of implementation. Revalidation will be paced in a way that is affordable, proportionate, and helps support improvements to both patient safety and the quality of care. The Revalidation Support Team will continue to support the NHS in England in piloting the components of revalidation and ensuring readiness of the system to begin revalidation in late 2012.

## 8. Conclusion

- 8.1 We recognise the need for the system for regulating healthcare workers across the UK and social workers and social care workers in England to continue to be sensitive to the needs of the health and social care sectors in all four countries of the UK. We remain firmly committed to taking forward the reform of workforce regulation on a UK wide basis. Consultation with the Devolved Administrations will be an early priority.
- 8.2 This Command Paper sets out a programme of reform to the system of professional regulation, which will support the objectives of the NHS (England) White Paper, 'Equity and Excellence' to put improved outcomes for service users at the heart of what the NHS and social care systems do. It affirms the Coalition Government's view of the importance of the existing system of professional regulation in securing the safety and wellbeing of those using health and social care services.
- 8.3 Our proposed reforms build on the reforms of the governance of the health professions regulators in 2008 and aim to deliver greater operational freedom to the regulators, balanced by strengthened accountability to both Parliament and the public. In the difficult economic climate, where pay restraint applies to parts of the health and social care workforce, we will also be looking to the CHRE and the regulators themselves to identify ways to constrain the growth and costs of the regulatory system.
- 8.4 Professional regulation must always be proportionate and effective, imposing the least cost and complexity consistent with securing safety and confidence for patients, service users, carers and the wider public. While it does not follow inevitably that statutory regulation is the most effective or efficient way of ensuring high quality care, we recognise the need to provide a more effective system for assuring the quality of unregulated staff and we believe that assured voluntary registration will make an important contribution to improving standards for the unregulated workforce.
- 8.5 A new 'Enabling Excellence through Professional Standards' Programme will be established by the Department of Health to implement the policy proposals in this paper within the life of the current Parliament.

## Annex A – Annual Expenditure, Numbers of Registrants and Fees by Professional Regulatory Body

Regulator	Annual Expenditure £	Numbers of Registrants	Fees
General Chiropractic Council	2,635,000 <sup>1</sup>	2,607	£1,000 £100 non-practising
General Dental Council	24,042,000 <sup>1</sup>	94,023	£576 Dentists £120 Dental care professionals <sup>2</sup>
General Osteopathic Council	2,848,000	4,250	£350 year 1 £500 year 2 £750 thereafter <i>Non-practising fee is 50% of normal fee</i>
General Medical Council	80,617,000 <sup>1</sup>	239,309	£410 with a licence £145 without a licence
General Optical Council	4,019,000 <sup>1</sup>	24,295	£219 for registrants £20 for students
General Pharmaceutical Council	15,900,000 <sup>3</sup>	58,664 <sup>4</sup>	£262 pharmacist £142 pharmacy technician
General Social Care Council	18,696,000 <sup>5</sup>	100,882	£30 Social Workers £10 students (though the actual costs of registration are heavily subsidised by taxpayers in England)
Health Professions Council	15,004,000	205,311	£76
Nursing and Midwifery Council	36,738,000	665,599	£76
Pharmaceutical Society of Northern Ireland	847,000	2,060	£372

*Source: Data about the numbers of registrants and fees charged has been obtained from the CHRE or the relevant regulatory body. The above expenditure figures have been drawn from the latest available annual review for each body. Unless otherwise indicated below, the figures are for 2009/10.*

<sup>1</sup> annual report is for calendar year 2009.

<sup>2</sup> from 31 July 2011.

<sup>3</sup> estimate of GPhC running costs is based on option 3 of the Impact Assessment of the Pharmacy Order 2009 which was published alongside the consultation on the draft regulations which established the General Pharmacy Council (approved as the Pharmacy Order 2010). NB the Council also charges annual fees for pharmacy premises registration.

<sup>4</sup> figure for GPhC is taken from final report of the predecessor body, the Royal Pharmaceutical Society of Great Britain.

<sup>5</sup> excludes education support grants.

## Glossary of Terms Used in This Command Paper

assured voluntary registration	A proposed system for ensuring that voluntary registers of health and social care workers meet specified standards to be set by the Council for Healthcare Regulatory Excellence.
command paper	A document issued by the Government and presented to Parliament as conveying information or decisions that the Government think should be drawn to the attention of Parliament.
devolved administrations	The Northern Ireland Assembly, the Scottish Parliament and the National Assembly for Wales.
fitness to practise	Where concerns are raised about a healthcare professional, the relevant regulatory body administers procedures to ascertain whether an individual remains fit to continue to practise the profession in view of the concerns. These procedures are referred to as fitness to practise procedures. A person who can demonstrably meet all of the relevant requirements of the profession is “fit to practise”.
healthcare worker	A person working in the healthcare sector, either within, or outside the NHS.
health professions regulators	The nine bodies with statutory responsibilities in respect of the regulation of healthcare professionals – these are the General Chiropractic Council; the General Dental Council; the Health Professions Council; the General Medical Council; the General Optical Council; the General Osteopathic Council; the General Pharmaceutical Council; the Nursing and Midwifery Council; and the Pharmaceutical Society of Northern Ireland.
practitioner	A person practising a profession or occupation.
profession	A recognisable group of people in an occupation requiring a distinct qualification and applying a defined body of knowledge.
professional regulation	The process of controlling the behaviour of members of a profession through setting rules or restrictions – in the UK the process of requiring professionals to abide by nationally set standards in order to use a protected title.
sanction	A restrictive requirement imposed by a regulatory body where a person is not considered to be “fit to practise” (or in the case of the GSCC to have committed misconduct). May for example include restrictions on practice, suspension from practice or removal from the professional register.
social care worker	A person working in the social care sector who is not a qualified social worker. The term encompasses numerous groups of workers including those who provide personal care in a person’s home and those who care for people in care home settings.
revalidation	A process whereby professionals are periodically required to demonstrate that they remain fit to practise their profession.

## Notes

- <sup>1</sup> Equity and excellence: Liberating the NHS, Department of Health, July 2010.
- <sup>2</sup> Reducing Regulation Made Simple: Less regulation, better regulation and regulation as a last resort, Better Regulation Executive, December 2010.
- <sup>3</sup> CHRE website ([www.chre.org.uk](http://www.chre.org.uk)), January 2011.
- <sup>4</sup> Performance review report 2009/10: Enhancing public protection through improved regulation, Council for Healthcare Regulatory Excellence, July 2010.
- <sup>5</sup> Reducing administrative burdens: effective inspection and enforcement. The Hampton Review Final Report. Published with the permission of HM Treasury on behalf of the Controller of Her Majesty's Stationery Office, March 2005.
- <sup>6</sup> This estimate is based on data from the Annual Population Survey (APS), Jan – Dec 2009, which includes data on numbers of regulated health and social care workers in the UK by sector of employment (public and private).
- <sup>7</sup> Right-touch regulation, Council for Healthcare Regulatory Excellence, August 2010.
- <sup>8</sup> The model was outlined in the GMC's 2004 Annual Report, page 4; [http://www.gmc.uk.org/ar\\_2004.pdf\\_25417172.pdf](http://www.gmc.uk.org/ar_2004.pdf_25417172.pdf).
- <sup>9</sup> This figure is a DH estimate based on figures reported in the latest annual reports available for each of the regulatory bodies – see Annex A.
- <sup>10</sup> Annual Report and Accounts, 2009/10, Council for Healthcare Regulatory Excellence, 2010.
- <sup>11</sup> Implementing the White Paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulators – final report and DH response to recommendations, Department of Health, June 2008.
- <sup>12</sup> Reducing Regulation Made Simple: Less regulation, better regulation and regulation as a last resort, Better Regulation Executive, December 2010.
- <sup>13</sup> Including social workers, but excluding pharmacy technicians.
- <sup>14</sup> The figure of 1.3 million workers quoted here is based on those groups where commitments to regulate were made in 'Trust, Assurance and Safety' in 2007, in response to recommendations of the House of Lords Select Committee on Science and Technology reported in November 2000 and in the report of The Prime Minister's Commission on the Future of Nursing and Midwifery in England in 2010. The figure is based on an estimated 995,000 people working in jobs in adult social care in England in residential and domiciliary care settings, excluding direct payments recipients in 2009 (Source: Skills for Care); 214,000 nursing auxiliaries & assistants (Source: Annual Population Survey (APS), Jan – Dec 2009); 32,378 healthcare scientists (Source: NHS Information Centre); 13,000 Acupuncturists, 1,500 Herbal Medicine Practitioners and 2,800 Traditional Chinese Medicine Practitioners (Source: Department of Health estimates); 15,000 psychotherapists and 32,000 counsellors (Source: UKCP estimates).
- <sup>15</sup> An Information Revolution – Liberating the NHS: A consultation on proposals, Department of Health, October 2010.
- <sup>16</sup> There are an estimated 1.75 million jobs in adult social care and 1.6 million people who are working in these jobs. The number of professionally qualified workers (which includes mainly social workers, registered nurses and occupational therapists) total 107,900. This means there are 1,492,100 unqualified workers. State of the Adult Social Care Workforce in England, 2010, Skills for Care, May 2010.
- <sup>17</sup> Report and Recommendations to the Secretary of State for Health on the conduct function of the General Social Care Council, Council for Healthcare Regulatory Excellence, September 2009.
- <sup>18</sup> Liberating the NHS: Report of the arms-length bodies review, Department of Health, 26 July 2010.
- <sup>19</sup> State of the Adult Social Care Workforce in England, 2010, Skills for Care, May 2010. The figure quoted is for the estimated number of people working in jobs in adult social care in England, 2009, by sector and type of service, excluding recipients of direct payments.
- <sup>20</sup> The regulation of social care workers is a devolved matter and some are already subject to forms of regulation in Northern Ireland, Scotland and Wales.



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