Regulating an occupation in fewer than all four UK countries

Implications for policy-makers, the public, and practitioners

Advice for the Scottish Government

February 2018

professional standards authority

About the Professional Standards Authority

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. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.[2] We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

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1 The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

2 Professional Standards Authority, 2015. *Right-touch regulation – revised*. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation. [Accessed 12/02/18]

Contents

1. Executive summary

1.1 The Scottish Government has commissioned the Professional Standards Authority (the Authority) under section 26A of the NHS Reform and Healthcare Professions Act 2002[3] to consider the implications of regulating a healthcare occupation in fewer than all four UK countries.[4]

1.2 Currently two groups in health and social care are regulated on this partial basis: pharmacy technicians are regulated in Great Britain but not Northern Ireland, while different groups of social care workers are regulated in Scotland, Wales, and Northern Ireland but not England.[5] In addition, the UK Government intends to regulate nursing associates in England, but the Scottish, Welsh and Northern Irish Governments currently have no plans to develop the role in their respective jurisdictions.

1.3 The picture we describe in this report of regulatory arrangements across the UK is complex. This is despite the fact that most professions are regulated UK-wide, either because their regulatory regime predates any devolution settlements, or, for those that do not, because of the way the four UK Governments have chosen to work together. The regulation of social workers and social care workers is a helpful example of how an initial government commitment to consistency across the UK can rapidly become eroded if each country has its own regulatory structures and devolved powers.

1.4 The legal advice we sought for this project did not identify any insurmountable issues with legislating for regulation in one UK country but not another. However, it did identify a number of areas of complexity to which careful thought would need to be applied, including:

- How extent and jurisdiction are determined
- How those trained elsewhere in the UK should be treated and recognised
- How and whether legislation can be drafted to engage only one nation and not require consent or approval of other nations
- The recognition and discovery of fitness to practise outcomes in other nations.

1.5 Many of these legal issues and complications arise where there is interaction between nations and in border regions. There are also complications where regulation is being introduced by amending existing legislation rather than creating new legislation. The primary public safety

[3] Available at: https://www.legislation.gov.uk/ukpga/2008/14/section/116#section-116-1. [Accessed 12/2/18]
[4] See Annex A for the full text of the commissioning letter.
[5] We describe the regulatory arrangements for these two groups in chapter 3.

concern relates to workers crossing borders to escape the consequences of an egregious act. Whether this would manifest in practice is hard to ascertain, and is likely to be linked to the level of personal investment in their career path, and socio-economic and demographic predictors of geographical mobility. It will always be the case, however, that individuals intent on taking advantage of what they may see as a loophole might constitute outliers in this respect.

1.6 There could of course be mitigations for the risk of practitioners subject to a regulatory sanction moving to an unregulated area to carry on practising, such as: communication with employers across the UK about the regulatory arrangements in other UK countries; the use of criminal record checks and employer references; and cooperation between regulatory bodies and other agencies.

1.7 Our report also considers the broader potential impacts on professionals, the workforce, and availability of workers, in both the short and the long term. We have turned here to international research evidence, and to the USA in particular. This is because its federal structures have led to significant variations in how professions are regulated.

1.8 All new regulations have unintended as well as intended consequences. The unintended consequences of introducing statutory regulation are not always easy to predict, but there is certainly evidence that it can create barriers to entry to work that have disruptive effects on the job market. What this means for the workforce in neighbouring unregulated areas is likely to depend on a multitude of factors, including the role itself, and the socio-economic characteristics of the practitioners. For example, we found no evidence of any particular impacts on the pharmacy technician or social care workforces in other UK countries, resulting from the current partial regulatory arrangements. However, it is possible that occupations with higher levels of geographical mobility are likely to be more affected. There is a chance that more highly-qualified practitioners might be attracted by roles in the regulated area because they meet the entry requirements to the register. On the other hand, those who are less qualified might remain in, or move to, unregulated jurisdictions. We cannot however quantify the chances of these phenomena occurring.

1.9 Another issue related to introducing regulation in one country but not another, is that of public and employer understanding, confidence, and expectations. There would need to be clear communication with the public, employers, and practitioners themselves about why regulation was being introduced in one country and not another. This would need to be underpinned by a clear narrative about the purpose of regulation, and an objective and evidence-based occupational risk assessment. Any such risk-assessment model would need to assess both the intrinsic risks related to an occupation, and any external factors, including existing means of

mitigation, that would inform a decision about whether and how to regulate a group.[6]

1.10 We accept that these risk-based approaches could result in different outcomes across the four UK countries. This would be the case if the role was materially different across countries, perhaps through significant discrepancies in the scopes of practice or the practice setting, or if there were existing mitigations in one country but not another. We caution however that long-term divergence from the commitment to regulate professions UK-wide could have significant impacts over time. What we find in the USA, which is perhaps an extreme example of this, is that geographical mobility of professionals across the country is significantly reduced by differences in regulatory requirements and scopes of practice between States. There may also be risks to public and employer confidence in and understanding of regulatory variations that are already complex.

1.11 The UK's plans to leave the EU and both current and predicted health and care workforce shortages, point to the need for governments to be alive to any consequences that might affect the supply of workers. We therefore suggest that UK-wide regulation should remain the norm, but that there may be circumstances where occupational risk assessment justifies a deviation from this norm. We propose that regulation of all groups should be UK-wide, unless:

- different approaches between UK countries are justified by the outcomes of an objective and robust assessment of occupational risk, *and*
- the impact of taking different approaches has been assessed as having a minimal impact on workforce supply across the UK, *or*
- measures can be taken that mitigate the impact on supply by facilitating the movement of workers around the UK.

1.12 Such an approach would enable governments to strike a balance between regulating only where necessary to address an identified risk of harm, and maintaining a unified approach to regulation UK-wide, in order to minimise the long-term impacts on the healthcare workforce.

[6] Our *Right-touch assurance* model sets out a two-stage process: the first stage involves an assessment of intrinsic risk; the second stage takes in a number of extrinsic factors including any assurance mechanisms already in place that could mitigate the intrinsic risks. Available at: https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm. [Accessed 12/2/18]

2. Background and introduction

2.1 The Scottish Government has commissioned the Professional Standards Authority (the Authority) under section 26A of the NHS Reform and Healthcare Professions Act 2002[7] to consider the implications of regulating a healthcare occupation on a non-UK-wide basis, or in fewer than all four UK countries.[8][9]

2.2 The challenges of regulating in one country but not another are helpfully encapsulated in the following quote, taken from a 2002 report by the Institute for Public Policy Research on the future regulation of health care assistants:

> *'Clearly, the most important thing will be to take account of the need to ensure portability of status between national settings, and also to ensure that national regulatory systems 'talk' to each other to ensure that mobility does not permit evasion of controls for those who do so maliciously.'*[10]

2.3 Currently two groups in health and social care are regulated on this partial basis: pharmacy technicians are regulated in Great Britain but not Northern Ireland, and different groups of social care workers are regulated in Scotland, Wales, and Northern Ireland but not England.[11] In addition, the UK Government intends to regulate nursing associates in England, but the Scottish, Welsh and Northern Irish Governments currently have no plans to develop the role in their respective jurisdictions.

2.4 Although the introduction of new statutory powers to regulate a healthcare occupation is a devolved power under the Scotland Act 1998, there is a four-country commitment among the UK Governments to UK-wide regulation.[12] This is not the case however for social care professional regulation, which has been implemented differently across the UK since the inception of the four social care councils in 2001.[13]

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[7] Available at: https://www.legislation.gov.uk/ukpga/2008/14/section/116#section-116-1. [Accessed 12/2/18]

[8] See Annex A for the full text of the commissioning letter.

[9] The commissioning letter makes clear that the Scottish Government reserves the right to decide whether this report should be published. We have nevertheless drafted the report so that it can be read and understood by an external audience, in the event that it is published.

[10] Johnson M, Institute for Public Policy Research, 2002. *The Future Health Worker: Regulation of Health Care Assistants*. Available at: http://www.ippr.org/files/uploadedFiles/projects/RegulationHealthCareAssis.PDF. [Accessed 12/2/18]

[11] We describe the regulatory arrangements for these two groups in chapter 3.

[12] See the Scottish Government website for more information about devolution in healthcare professional regulation, including a list of the professions that are regulated by statute and whether they are regulated on a reserved or devolved basis: http://www.gov.scot/Topics/Health/NHS-Workforce/Regulation. [Accessed 12/2/18]

[13] For example, social workers are regulated across the UK under devolved legislation for Scotland, Wales, and Northern Ireland, and UK legislation applying to England only for England.

2.5 As this is a commission from the Scottish Government, we have focused primarily on issues relating to Scotland, however many of the points we raise have broader applicability. In addition, we have not made any assumptions about the occupation or type of occupation that would be subject to these arrangements, although we have used the arrangements for social care workers and pharmacy technicians as helpful examples and sources of evidence.

2.6 The commissioning letter requests that our advice cover the following:

- '*Consideration of issues resulting from practitioners moving between similar roles across borders on a regulated and non-regulated basis, and whether these issues might vary from one group to another and why (for example according to the level of risk);*
- *Legal issues arising from regulating in only one country or less than all four countries;*
- *A comparison with the approaches to social care worker regulation, which are different in all four countries;*
- *Any other issues that the Authority considers relevant, and particularly unintended consequences, that might impact on quality of care and outcomes*.'

2.7 In developing this advice, we have completed the following tasks:

- Sought legal advice on the regulatory, constitutional and other legal issues related to regulating in part of the UK
- Carried out desk research into regulatory arrangements for pharmacy technicians and social care workers in the UK
- Interviewed a range of stakeholders in specific roles to understand what issues they perceive, if any, with regulating a group in fewer than all four UK countries[14]
- Considered research from federal countries on the long-term impact of having differing regulatory arrangements across different jurisdictions
- Carried out desk research into issues arising from these types of regulatory arrangements.

2.8 Our advice takes account of the current political environment including devolution arrangements and the plans for the UK to withdraw from the European Union.

2.9 To complete this project, we began by setting out a range of theoretical problems, before moving on to look for evidence of their materialising in practice. Our conclusions consider both the theoretical and the actual issues identified. We are aware that the scale of the project has not allowed

[14] For this project, we spoke to the Scottish Social Services Council, Unison Scotland, the National Care Association, and Northumberland County Council.

for extensive primary research, and have made some suggestions for areas where further work could be beneficial.

2.10 We have categorised the types of issue, both potential and actual, covered in this report as follows:

- Constitutional, regulatory and other legal issues
- Unintended consequences.

2.11 This advice is drafted primarily for policy-makers in government working on primary and secondary legislation. Some of the issues identified in the report may also be of interest to regulators, and other stakeholders.

3. Overview of current situation

3.1 We mentioned in our introduction that currently pharmacy technicians and social care workers are subject to statutory regulation in parts, but not all of the UK. In this chapter, we describe the regulated and unregulated occupations that might be considered for statutory regulation in the future. We go on to consider in more detail the regulatory arrangements currently in place for pharmacy technicians and social care workers.

Regulated, registered and other groups

3.2 Under the current regulatory framework, some health and care occupations are regulated by statute, while others are not. Health professionals in the UK, and social workers in England, are regulated by the statutory regulatory bodies overseen by the Professional Standards Authority, and appear on the register relevant to their profession.

3.3 Most health and care professions currently regulated by statute come under UK-wide legislation.[15] However, for professions that were not regulated when the Scotland Act 1998 came into force, regulation is devolved to the Scottish Parliament – although four-country working agreements have meant that, to date, any such groups have been regulated UK-wide.

3.4 The majority of statutory regulators cover the whole of the UK with the exception of the General Pharmaceutical Council (GPhC) which excludes Northern Ireland – pharmacists here are covered by the Pharmaceutical Society of Northern Ireland (PSNI). In addition, social workers in Northern Ireland, Scotland and Wales are regulated by separate bodies: respectively the Northern Ireland Social Care Council (NISCC), the Scottish Social Services Council (SSSC) and Social Care Wales (SCW).

3.5 Other occupations in the health and care sector are:

- listed voluntarily on registers held by bodies accredited by the Authority[16]
- listed voluntarily on registers held by membership bodies not accredited by the Authority, or
- not covered by either of the above.

[15] With the exception of pharmacists and pharmacy technicians, for whom regulation is devolved to Northern Ireland.

[16] Professional Standards Authority, *Our work with accredited registers*. [Online]. Available at: http://www.professionalstandards.org.uk/what-we-do/accredited-registers [Accessed: 31/10/2016]

Statutory regulation

3.6 We oversee nine statutory professional regulators,[17] which cover a total of 32 professions. In addition, there is a dedicated social care worker regulator for each of the devolved nations. A list of regulated health and care professions is available at Annex C. Each regulator maintains a list of registrants, and all of those practising in these professions are required to register with the relevant regulatory body and abide by their standards of conduct and competence.

3.7 The role of the statutory regulators is to protect patients by setting standards for professional practice and conduct, maintaining a register of professionals who meet these standards, and taking action when standards are not met. They also quality assure the provision of qualifying education.

3.8 All the regulators handle complaints made by service users, employers and others about health and care professionals. The most serious cases which pose a risk to the public, or where there is a wider public interest in taking action, are referred to formal hearings in front of fitness to practise panels. Professionals whose fitness to practise is deemed to be impaired can be struck off the register, and prevented from practising in the future[18] or face a range of other sanctions including temporary suspension from the register, conditions of practice, or warnings.

Accredited registers

3.9 A number of other health and care occupations that are not statutorily regulated have membership bodies, which hold registers of practitioners who meet their standards. Unlike statutory regulation, there may be more than one register for a single occupation. The Professional Standards Authority accredits many of these membership bodies as register holders under the accredited registers programme (24 registers were accredited at the time of writing)[19].

3.10 Registers that have received accreditation from the Authority must comply with a set of standards, including providing clear information to the public, setting standards for education and training for practitioners and having a clear and transparent complaints process. This helps to ensure public safety by enabling members of the public to choose a practitioner who is registered with an accredited body. In addition, the registers we accredit are required to recognise each other's fitness to practise decisions, which means that if a practitioner is struck off an accredited register they are not

[17] 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.
[18] Although they can apply to return to the register after a period of time specified in legislation, usually five years.
[19] Professional Standards Authority, *Find an accredited register*. [Online]. Available at: http://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register [Accessed: 31/10/2016]

allowed to join another one in the same occupation (or another in a different occupation if removed for misconduct). A list of the organisations currently accredited by the Authority showing the professions which they cover and the countries they operate in is available at Annex C.

Health and care occupations not covered by statutory regulation or accredited registers

3.11 There remain a number of existing health and care occupations that are currently covered by neither statutory regulation nor the accredited registers programme. These occupations may be listed on a register held by an organisation that is not accredited by the Professional Standards Authority, or may not currently be represented by a membership body. A non-exhaustive list of membership bodies that hold a register but are not accredited by the Authority is available at Annex C, along with a list of occupations that are currently unregulated and not covered by an accredited register.[20] This table also shows one occupation that is currently in development, namely that of nursing associates.

3.12 We have grouped the occupations that are neither regulated, nor on an accredited register into four main categories and given examples of some of the occupations within these groups. In relation to social care, this differs across the four countries of the UK:

- **Physical health** – occupations include different types of medical associates, health care assistants, nursing associates (first cohort currently in training, to be regulated by the Nursing and Midwifery Council (NMC)), and complementary therapist practitioners not covered by accredited registers
- **Mental health and wellbeing** – psychological therapy practitioners and counsellors not covered by relevant accredited registers
- **Social work and care** – including care workers/care assistants, home care workers, personal assistants (in England)
- **Health science, promotion and protection** – health records and patient information, clinical management.

3.13 At the time of writing, the four UK Governments had recently consulted jointly on whether to regulate four assistant roles in medicine across the UK:

- Physician Associates
- Physicians' Assistants (Anaesthesia)
- Surgical Care Practitioners
- Advanced Critical Care Practitioners.[21]

[20] This is intended to be illustrative and not exhaustive, as new roles are regularly emerging, and the accredited registers programme continues to attract new registers on a regular basis.
[21] The consultation is available at: https://www.gov.uk/government/consultations/regulating-medical-associate-professions-in-the-uk. [Accessed 12/2/18]

3.14 In addition, the UK Government had just closed a consultation on amendments to the NMC's legislation to give them powers to regulate nursing associates in England.[22]

Pharmacy technicians

Background and current situation

3.15 Responsibility for statutory regulation of pharmacists in the UK is shared between two regulatory bodies: the GPhC, which covers England, Scotland and Wales, and the PSNI. The GPhC regulates pharmacists, pharmacy technicians and pharmacy premises, while the PSNI regulates pharmacists and pharmacy premises.[23] Although the GPhC has powers to inspect pharmacy premises, in Northern Ireland, inspections are carried out by the Department of Health.

3.16 The Royal Pharmaceutical Society of Great Britain (RPSGB), which had regulatory powers in Great Britain until they were transferred to the GPhC in 2010, originally set up a voluntary register of pharmacy technicians in Great Britain in 2005.[24] Statutory regulation of pharmacy technicians in England, Scotland and Wales was then introduced initially on a voluntary basis in 2009, under the Pharmacists and Pharmacy Technicians Order 2007,[25] and the Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009.[26] Registration became compulsory in 2011, after the transfer to the new regulator.[27] The title 'pharmacy technician' is now protected by law, and it is a criminal offence to use it in Great Britain without being registered as such with the GPhC. It is accompanied in the Pharmacy Order by a description of the activities that can only be performed by pharmacists or pharmacy technicians:

> *3(2) 'For the purposes of this Order, a person practises as a pharmacist or a pharmacy technician if, whilst acting in the capacity of or purporting to be a pharmacist or a pharmacy technician, that person undertakes any work or gives any advice in relation to the preparation, assembly, dispensing, sale, supply or use of medicines,*

[22] The consultation is available at: https://www.gov.uk/government/consultations/regulation-of-nursing-associates-in-england. [Accessed 12/02/18]
[23] The GPhC also has powers of inspection, while in Northern Ireland, these powers are granted to the Government.
[24] Royal Pharmaceutical Society of Great Britain, 2004, *Society opens its voluntary register for pharmacy technicians*, Pharmaceutical Journal. Available at: http://www.pharmaceutical-journal.com/pj-online-the-society-society-opens-its-voluntary-register-for-pharmacy-technicians/20013684.article. [Accessed 10/07/2017]
[25] Available at: https://www.legislation.gov.uk/uksi/2007/289/contents/made. [Accessed 06/02/18]
[26] Available at: https://www.legislation.gov.uk/uksi/2009/1182/made. [Accessed 06/02/18]
[27] Royal Pharmaceutical Society of Great Britain, 2009, Annual Report 2009, pg. 9. Available at: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Annual%20reviews/Annual%20Review%202009.pdf. [Accessed 18/07/2017]

the science of medicines, the practice of pharmacy or the provision of healthcare.'[28]

The role

3.17 Pharmacy technicians manage the supply of medicines in a community pharmacy and assist pharmacists with advisory services. In hospitals, they do more specialised work such as manufacturing or preparing complex medicines.[29] They work as part of the pharmacy team which can also include pharmacists, medicines counter assistants and pharmacy/dispensing assistants.[30]

3.18 Currently, if a pharmacy technician practising in Northern Ireland wants to practise in Great Britain, they must be registered with the GPhC.[31] In the Republic of Ireland pharmacy technicians are not regulated. There were 23,318 pharmacy technicians on the GPhC's register in 2015/16.[32] In the absence of a statutory register, it is hard to know exactly how many pharmacy technicians are working in Northern Ireland. One figure from 2009 shows there were 354 pharmacy technicians registered with the Northern Ireland Centre for Pharmacy Learning and Development.[33]

3.19 To qualify as a pharmacy technician in Great Britain and register with the GPhC, an applicant needs to complete both a GPhC-approved competency-based qualification and a knowledge-based qualification.[34] This includes 'two years consecutive work-based experience under the direction of a pharmacist to whom the trainee is directly accountable for not less than 14 hours per week'.[35] A qualification can either be gained on a GPhC-accredited course or be a GPhC-recognised qualification. The GPhC recognises the qualifications awarded by City & Guilds, Pearsons/Edexcel

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[28] See 3(2) of the Pharmacy Order, available at: https://www.pharmacyregulation.org/sites/default/files/1116_pharmacy_order_consolidated.pdf
[29] Health Education England, Pharmacy technician. Available at: https://www.healthcareers.nhs.uk/explore-roles/pharmacy/pharmacy-technician. [Accessed 10/07/2017]
[30] NI Direct Government Services, Careers in Pharmacy. Available at: https://www.nidirect.gov.uk/articles/careers-pharmacy. [Accessed 10/07/2017]
[31] General Pharmaceutical Council, *Do I need to register if I work in Northern Ireland?* Available at: https://www.pharmacyregulation.org/content/do-i-need-register-if-i-work-northern-ireland. [Accessed 18/07/2017]
[32] General Pharmaceutical Council*, Annual report Annual fitness to practise report Annual accounts 2016/17*, pg.37. Available at: https://www.pharmacyregulation.org/sites/default/files/pdf/gphc_annual_report_2016-17.pdf. [Accessed 10/07/2017]
[33] Department of Health, Social Services and Public Safety, 2010, Review of development needs of pharmaceutical staff in hospital practice, pg. 25. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/review-development-needs-report.pdf. [Accessed 18/07/2017]
[34] General Pharmaceutical Council, Pharmacy technician education and training. Available at: https://www.pharmacyregulation.org/education/pharmacy-technician. [Accessed 10/07/2017]
[35] General Pharmaceutical Council, Pharmacy technician education and training. Available at: https://www.pharmacyregulation.org/education/pharmacy-technician. [Accessed 10/07/2017]

and the Scottish Qualifications Authority. Courses provided by Buttercups and the National Pharmacy Association are accredited by the GPhC.[36]

3.20 In Northern Ireland, training is a combination of 'practical experience and study at a college, or open learning' over two years, which culminates in an NVQ level 3 in Pharmacy Services Skills.[37]

3.21 The annual renewal fee for pharmacy technicians registered with the GPhC is £118.[38]

3.22 A pharmacy technician is 'fit to practise' if they have:

> *'the skills, knowledge, character and health necessary to do their job safely and effectively, and when they act professionally and meet the principles of good practice set out in our various standards, guidance and advice.'*[39]

3.23 If concerns are raised about a registered pharmacy technician's suitability to practise, the GPhC registrar may refer the case to the Investigating Committee.[40] The Committee will decide whether a case should be considered by the Fitness to Practise Committee. If it decides that a case does not need to be referred, it may:

- dismiss the case
- give a warning to the registrant and decide that details of the warning should be recorded in the register
- give advice to the registrant, or any other person or organisation involved in the investigation
- agree undertakings with the registrant
- decide that a criminal prosecution should be initiated.

3.24 If the case is referred to the Fitness to Practise Committee and the Committee finds that a registrant's fitness to practise is impaired, it can:

- give a warning to the registrant and decide that details of this warning should be recorded in the register
- give advice to any other person or organisation involved in the investigation

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[36] General Pharmaceutical Council, Approved pharmacy technician courses. Available at: https://www.pharmacyregulation.org/education/pharmacy-technician/accredited-courses. [Accessed 26/10/2017]

[37] NI Direct Government Services, Careers in Pharmacy. Available at: https://www.nidirect.gov.uk/articles/careers-pharmacy [Accessed 10/07/2017]

[38] Fees, General Pharmaceutical Council. Available at: https://www.pharmacyregulation.org/registration/registering-pharmacy-technician/fees [Accessed 23/10/2017]

[39] General Pharmaceutical Council, *What is 'fitness to practise'?* Available at: https://www.pharmacyregulation.org/raising-concerns/what-fitness-practise [Accessed 26/10/2017]

[40] Or in limited circumstances, the Registrar may refer a case directly to the Fitness to Practise Committee.

- remove the registrant from the register
- suspend the registrant from the register for up to 12 months
- place conditions on the registrant's registration for up to three years.

3.25 If, on the other hand, the Fitness to Practise Committee decides that the professional's fitness to practise is not impaired, it may:

- give a warning to the registrant and decide that details of the warning should be recorded in the Register
- give advice to the registrant, or any other person or organisation involved in the investigation. [41]

3.26 In 2016/17, only one pharmacy technician was struck off by the GPhC.

3.27 The GPhC also sets standards for continuing professional development (CPD) for pharmacy technicians. The principal requirements are as follows:

- to make a minimum of nine CPD entries per year which reflect the context and scope of their practice as a pharmacy technician
- to keep a record of CPD that complies with the good practice criteria for CPD recording
- to record how their CPD has contributed to the quality or development of their practice using the GPhC CPD framework.
- to submit CPD records to the GPhC on request.[42]

Views and impact

3.28 In 2016, the Department of Health for Northern Ireland ran a consultation on the future of professional regulation of pharmacy professionals and pharmacies in Northern Ireland.[43] In the consultation paper, the Department noted the difference in regulatory arrangements between pharmacy technicians in Great Britain and those in Northern Ireland, although it did not express a view, nor did it ask any specific questions on this.[44]

3.29 In response to this consultation, the Association of Pharmacy Technicians UK (APTUK) was supportive of the GPhC regulating pharmacy technicians in Northern Ireland. The APTUK noted that pharmacy technicians were

[41] General Pharmaceutical Council, Sanctions. Available at: https://www.pharmacyregulation.org/raising-concerns/hearings/sanctions. [Accessed 23/10/2017]
[42] See https://www.pharmacyregulation.org/sites/default/files/Standards%20for%20continuing%20professional%20development%20s.pdf. [Accessed 12/02/18]
[43] Available at: https://www.health-ni.gov.uk/consultations/review-pharmacy-regulation-northern-ireland. [Accessed 12/02/18]
[44] Department of Health, Northern Ireland, 2017, *Future of Pharmacy Regulation in Northern Ireland Consultation Summary Report*, pg. 9. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/pharmacy-reg-summary-report.pdf. [Accessed 10/11/2017]

'embedded into GPhC operations' such as fitness to practise systems and that this would be 'beneficial' to pharmacy technicians in Northern Ireland.[45]

3.30 Conversely, the Pharmacists' Defence Association (PDA) argued that current registration of pharmacy technicians in Great Britain had been poorly handled, and introduced by 'government edict'. The registration process had not been led by pharmacy technicians, did not arise from the development of 'traditional professional consciousness' built over time or ambitions in the pharmacy profession, and was not 'developed by a group with highly specialist skills, expert knowledge and rigorous high-level training'.[46]

3.31 Both organisations commented on the subject of fees in their consultation responses: the APTUK pointed out that any introduction of regulation for pharmacy technicians would need to be cognisant that pharmacy technicians are predominantly female and 'often work part-time' when setting registration fees.[47] The PDA noted that the idea of introducing GPhC registration for pharmacy technicians in Northern Ireland would mean pharmacy technicians would have to pay a registration fee.[48] Concern over registration fees for pharmacy technicians in the UK had previously been raised by UNISON. The trade union argued that pharmacy technicians in Great Britain were paying a 'registration fee which [was] disproportionate to their earnings and those imposed by comparative regulators'.[49]

3.32 The Regulation and Quality Improvement Authority (RQIA) supported the registration of technicians in Northern Ireland as they argued this would improve patient safety by 'ensuring only those qualified, competent and under a duty to maintain high standards can work as pharmacy technicians'. The RQIA went on to say that registration would 'allow technicians to up-skill in order to take on greater responsibilities and work within a structured career pathway'. The RQIA also pointed out that registration would 'also

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[45] Association of Pharmacy Technicians UK, Future of Pharmacy Regulation in Northern Ireland Consultation Response Questionnaire, Pg. 11. Available at: http://www.aptuk.org/media/dynamic/files/2016/06/20/review-pharmacy-ni-questionnaire_APTUK_response_June_2016.pdf. [Accessed 10/07/2017]

[46] Pharmacists' Defence Association, 2016, *The Department of Health, Social Services and Public Safety on the Future of Pharmacy Regulation in Northern Ireland*, pg. 15. Available at: https://www.the-pda.org/wp-content/uploads/dhssps_response_201606-2.pdf. [Accessed 10/07/2017]

[47] Association of Pharmacy Technicians UK, Future of Pharmacy Regulation in Northern Ireland Consultation Response Questionnaire, pg. 14. Available at: http://www.aptuk.org/media/dynamic/files/2016/06/20/review-pharmacy-ni-questionnaire_APTUK_response_June_2016.pdf. [Accessed 10/07/2017]

[48] Pharmacists' Defence Association, 2016, *The Department of Health, Social Services and Public Safety on the Future of Pharmacy Regulation in Northern Ireland*, pg. 15. Available at: https://www.the-pda.org/wp-content/uploads/dhssps_response_201606-2.pdf. [Accessed 10/07/2017]

[49] Law Commissions, 2013, *Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis*, pg. 28. Available at: http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_analysis-of-responses_complete.pdf. [Accessed 08/05/2017]

allow pharmacists to delegate roles without fear of legal sanction and release time for pharmacists to deal with more patient facing activities'.[50]

3.33 In 2016, the University of East Anglia interviewed pharmacy technicians across the UK, in order to understand pharmacy technician infrastructure and their roles. A pharmacy technician in Northern Ireland who had trained through the National Pharmacy Association in England, and was registered with the GPhC, noted that they had completed an 'Accuracy Checking Accreditation' but that this was not a requirement to work as a technician in Northern Ireland. They went on to comment that there was little training or CPD for Northern Ireland technicians. Instead they undertake 'pharmacist led CPD with the Northern Ireland Centre for Pharmacy Learning and Development'.[51] In response to the researchers asking for a description of barriers to career development in hospital settings, one pharmacy technician argued:

> '*In Northern Ireland the main barrier is lack of registration, regulation and compulsory CPD. Until techs can register they will not be valued as professionals in their own right. The PSNI have to acknowledge the vital role pharmacy technicians have and bring us in line with the rest of the United Kingdom'.*[52]

3.34 Another pharmacy technician believed that they were not 'seen as professionals' due to lack of registration. The same technician also commented that banding of pharmacy technicians was 'consistently lower' than in Great Britain with less chance of progression and fewer opportunities at higher banding. [53]

Social care workers

Background and current situation

3.35 Currently, responsibility for the regulation of social workers is shared by four bodies across the UK:

- Health and Care Professions Council (England) (HCPC)

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[50] Regulation and Quality Improvement Authority, 2017, *Review of Governance Arrangements in HSC Organisations that Support Professional Regulation*, pg. 20. Available at: https://www.rqia.org.uk/RQIA/files/a8/a8547025-1073-4ef4-bb02-401bd088d99b.pdf. [Accessed 08/05/2017]

[51] University of East Anglia, 2016, *Identifying the roles of pharmacy technicians in the UK*, pg. 52. Available at: https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c. [Accessed 12/02/18]

[52] University of East Anglia, 2016, *Identifying the roles of pharmacy technicians in the UK*, pp. 154-5. Available at: https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c. [Accessed 12/02/18]

[53] University of East Anglia, 2016, *Identifying the roles of pharmacy technicians in the UK*, pp. 155-6. Available at: https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c. [Accessed 12/02/18]

- Social Care Wales
- Northern Ireland Social Care Council
- Scottish Social Services Council.

3.36 In addition, the regulators in the devolved administrations now regulate a number of different groups of social care workers. It is on these groups that we will focus in this report, because, unlike social workers, they are not regulated in England, and therefore constitute a helpful precedent for this commission.[54]

3.37 Devolution of the regulation of social care workers began in 2001, by means of the Care Standards Act, which set up separate regulators for these groups in England and Wales, the Regulation of Care (Scotland) Act, and the Health and Personal Social Services Act (Northern Ireland). These pieces of legislation set up, respectively: the General Social Care Council[55] and the Care Council for Wales (CCW),[56] the Scottish Social Services Council, and the Northern Ireland Social Care Council. These four regulators were initially set up with similar legislation, a shared code, and the same regulatory powers – namely compulsory statutory regulation of social workers, with a view to extending these powers to social care workers in time.

3.38 Setting up four different regulatory bodies for social care workers was not without controversy, however. One proposed amendment to the Care Standards Bill aimed to extend the GSCC's remit to the whole of the UK:

> *'However, the Bill does not establish a council but two separate bodies, one for England and one for Wales. Each will be organised differently. No mention is made of Scotland or Northern Ireland. We have a United Kingdom Central Council for Nursing and a British Medical Association. This clause gives the impression that for social care staff the United Kingdom does not exist. Already questions are raised as to whether the existing social care qualifications meet European standards. Are we to settle for up to four different councils which are separately and differently organised? Even worse, the Bill provides no machinery by which councils can exchange vitally important information or act in concert.*
>
> *I well understand the implications of devolution, but surely it is possible for the Government to find a solution whereby, in a matter of such importance and sensitivity, it is possible to have a United Kingdom arrangement for the regulation, registration and deregistration of social care staff. It is no use noble Lords from time*

[54] It is worth noting that the regulatory arrangements for social workers also present certain challenges, but we did not feel these were within the scope of the commission.
[55] Now closed – regulation of social workers taken on by the Health and Care Professions Council.
[56] Functions now transferred to a new body, Social Care Wales. It has a range of additional functions to do with workforce and practice improvement.

to time, understandably, expressing horror when a member of staff who behaves unacceptably in one part of the country leaves his job only to be employed elsewhere and, at the same time, failing to use this opportunity to create one United Kingdom general social care council. I beg to move."[57]

3.39 The then Minister, Lord Hunt of King's Heath, responded as follows:

'The logic of devolution is that all four councils can properly adopt different approaches. However, all the countries are committed to alignment where that is possible. The commitment has already been demonstrated; for example, the four UK countries have already commissioned the initial drafting of the codes of conduct for social workers as a joint exercise. That is an excellent foundation on which to go forward."[58]

3.40 Since that time, however, one of these bodies has closed (the GSCC), with the regulatory functions taken on by an existing multi-professional regulator (the HCPC)[59] and one has transformed into a new regulatory body with additional functions (the CCW has become SCW). The professional codes have evolved to the point where they are no longer aligned. And most significantly, while social workers are regulated in all countries of the UK, there are now major variations in the regulatory remits of each body, particularly with respect to the regulation of social care workers. Most of the devolved administrations initially prioritised registration of those working at manager level and subsequently moved on to register residential care workers and more recently domiciliary care workers. For a table of those groups that are currently regulated in Wales, Scotland, and Northern Ireland, see Annex B.

3.41 There is currently a Memorandum of Understanding in place between the regulators with responsibility for regulating social care workers across the devolved nations. This covers information sharing and sets out the working relationship in relation to the regulation of social workers and the approval of social work education across the UK, and the framework for cooperation in relation to the regulation of the social care workforce.

3.42 The different countries recognise different qualifications for different roles. Some are equivalent but others require applicants to complete additional training to be eligible to register to work there.[60]

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[57] HL Deb, 13 January 2000, c852-853. Amendment moved by Lord Laming. Available at: https://publications.parliament.uk/pa/ld199900/ldhansrd/vo000113/text/00113-24.htm#00113-24_spnew3. [Accessed 12/02/18]

[58] HL Deb, 13 January 2000, c854. Available at: https://publications.parliament.uk/pa/ld199900/ldhansrd/vo000113/text/00113-24.htm#00113-24_spnew8. [Accessed 12/02/18]

[59] Primary legislation has now been passed to create a dedicated social worker regulator for England.

[60] *Memorandum of Understanding between the Care Council for Wales, the Health and Care Professions Council, the Northern Ireland Social Care Council and the Scottish Social Services Council*. [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-

The roles

3.43 'Social worker' is a protected title in all parts of the UK, but the titles attached to the different social care roles are not protected. Social care workers provide care to vulnerable individuals and groups of all ages who require varying kinds of non-medical support sometimes due to social marginalisation, disadvantage or special needs. Definitions of specific roles and remits vary across the four countries of the UK. However, the Care Standards Act 2000 includes the following definition of social care worker:

> '"*Social care worker" means a person (other than a person excepted by regulations) who—*
>
> *(a) engages in relevant social work (referred to in this Part as a "social worker");*
>
> *(b) is employed at a children's home, care home or residential family centre or for the purposes of a domiciliary care agency, a fostering agency or a voluntary adoption agency;*
>
> *(c) manages an establishment, or an agency, of a description mentioned in paragraph (b); or*
>
> *(d) is supplied by a domiciliary care agency to provide personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.'*[61]

3.44 Based on the above definition, broadly speaking, the main types of social care work can be described as follows:

- Social work
- Residential childcare, providing support to children and young people in care
- Adult care home supporting older people or adults with physical or intellectual disabilities
- Domiciliary care providing support to individuals living in their own homes through visits in which they may carry out household tasks, personal care or any other activity that allows the individual to maintain their independence and quality of life
- Management of any of the above services.

3.45 Other types of role include: day care support workers, who may work in a day care centre and provide temporary or respite care for individuals; and supported living support workers who help people living in sheltered accommodation rather than a care home setting. None of the social care regulators currently regulate personal assistants.

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library/publications/37-about-the-sssc/2332-memorandum-of-understanding-between-the-four-countries [Accessed: 03/08/2017]

[61] Care Standards Act 2000, Part IV Social Care Workers, Section 55. [Online] Available at: https://www.legislation.gov.uk/ukpga/2000/14/pdfs/ukpga_20000014_en.pdf. [Accessed 31/10/2017]

Wales

3.46 In Wales, social care workers are regulated by Social Care Wales (SCW). SCW came into being in 2017 – up until this point, regulation of these groups was the responsibility of the Care Council for Wales.

3.47 As of October 2017, there were 4512 people on the social care part of the SCW Register including residential child care managers, adult care home managers, domiciliary care managers and residential child care workers.[62] In addition, domiciliary care workers will be required to be registered from 2020.[63] Registered social care providers are required to employ only workers registered with SCW in certain roles.

3.48 Social care workers registered in Wales are required to pay an annual fee of £10 whilst social care managers are required to pay £30 annually[64]. We understand that, like the CCW, the new regulator will receive funding from the Welsh Government.[65]

3.49 Along with social workers and social work students, all social care workers must demonstrate that they:

- '*are appropriately qualified*
- *are physically and mentally fit to practise*
- *have the character and competence*
- *agree to follow the Code of Professional Practice for Social Care*
- *intend to practise social care in Wales*
- *will practise in the field their application relates to*.'

3.50 If any of these criteria are not met, then the regulator can refuse registration and can also impose sanctions including restrictions on working or training.[66]

3.51 With regard to education and training, SCW requires those registering for certain roles to hold recognised qualifications, however they currently only quality assure and approve social work courses. In relation to the transferability of qualifications across the UK, Wales and Northern Ireland use broadly the same qualification framework although SCW recommend that certain groups of adult care workers complete an additional learning

[62] Social Care Wales, *What is registration?* [Online] Available at: https://socialcare.wales/registration/what-is-registration. [Accessed: 31/10/2017]
[63] Social Care Wales, *Registration of domiciliary care workers*. [Online] Available at: https://socialcare.wales/registration/domiciliary-care-workers-what-you-need-to-know. [Accessed: 31/10/2017]
[64] Social Care Wales, *Registration fees*. [Online] Available at: https://socialcare.wales/registration/registration-fees. [Accessed: 31/10/2017]
[65] As shown in the most recent accounts for the Care Council for Wales, which are available here: http://www.assembly.wales/laid%20documents/agr-ld10721/agr-ld10721-e.pdf. [Accessed 12/02/18]
[66] Social Care Wales, *What is registration?* [Online] Available at: https://socialcare.wales/registration/what-is-registration. [Accessed: 31/10/2017]

unit that is not required in Northern Ireland. SCW also recognises the equivalent qualifications in Scotland. For the majority of roles, workers relocating from England are required to complete some additional training to meet the registration requirements for Wales.[67] As well as the requirements for roles which require registration with SCW, the Care and Social Services Inspectorate Wales requires a minimum standard of training for any staff working in services which they regulate.

3.52 Social Care Wales requires social care workers to complete 90 hours of post registration training and learning (PRTL) in a three-year registration period.[68] They also endorse a range of CPD training and qualifications.

3.53 If concerns are raised about a registered person's suitability to work in social care, Social Care Wales will investigate and can bring fitness to practise proceedings against a registrant which may result in a sanction. If the panel finds that fitness to practise is impaired, then they can impose a range of disposals including:

- Removal by agreement
- Undertakings
- No further action
- Warning – about future conduct or performance
- Conditional Registration Order
- Suspension Order
- Removal Order.

3.54 If fitness to practise is not impaired then the Panel can close the case with no further action, issue a warning or refer to specific standards in the Code of Professional Practice for Social Care.

3.55 In 2016/17, there were eight final fitness to practise decisions made about social care workers, which resulted in five removals – from a registrant base of just over 4,500.[69] For that year therefore, social care workers constituted approximately one third of all the decisions, though we stress that the numbers are very small.

[67] Care Council for Wales, *Qualifications across boundaries – Comparison of Competence Qualifications Across the UK, Updated November 2016.* [Online] Available at: https://socialcare.wales/cms_assets/file-uploads/Qualifications-across-boundaries.pdf. [Accessed: 02/08/2017]
[68] Social Care Wales, *Post registration training and learning (PRTL).* [Online] Available at: https://socialcare.wales/registration/renewing-your-registration#section-396-anchor. [Accessed: 03/08/2017]
[69] Fitness to practise data for 16/17 supplied by Social Care Wales.

Scotland

3.56 In Scotland, the Scottish Social Services Council (SSSC) regulates social service workers[70] working in a relevant job in a service registered by the Scottish Care Inspectorate. Roles currently covered by SSSC registration include child care workers and managers and adult care workers and managers. In late 2017 there were over 95,758 social care workers on the social service part of the SSSC register[71]. The SSSC also opened its register to 45,000 care at home workers and workers in housing support services on 2 October 2017[72]. Workers must now register within six months of starting a new role[73]. SSSC also regulates social workers and social work students. Registered social care providers are required to employ only workers registered with SSSC in certain roles.

3.57 Those who are registered with any of the UK-wide statutory regulators or the other Care Councils in Wales or Northern Ireland are not required to register again with the SSSC, and are covered for any social service position where the SSSC registration is otherwise required.[74]

3.58 Social service workers registered with the SSSC are required to pay an annual registration fee. The SSSC introduced a new fee structure from September 2017, which requires annual fees of £25 for support workers, £35 for supervisors and practitioners and residential childcare workers and £80 for managers.[75] The SSSC also receives funding from the Scottish Government.[76]

3.59 Social service workers registered with the SSSC must be working in a relevant role in a service regulated by the Care Inspectorate, and:

- Adhere to the SSSC Code of Practice[77]

[70] This is the term used by the SSSC to describe what we have referred to elsewhere in the report as 'social care workers'.
[71] Scottish Social Services Council 2016, *A trusted, skilled and valued social service workforce.* [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=2445. [Accessed: 02/11/2017]
[72] Scottish Social Services Council, *Social service workforce Register opens for 45,000 workers in care at home and housing support*. [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/press-releases/social-service-workforce-register-opens-for-45,000-workers-in-care-at-home-and-housing-support. [Accessed: 31/10/2017]
[73] Scottish Social Services Council, *It's time to register - care at home and housing support workers*. [Online] Available at: http://www.sssc.uk.com/registration/do-i-need-to-register/it-s-time-to-register-care-at-home-and-housing-support-workers. [Accessed: 31/10/2017]
[74] Scottish Social Services Council, *Social Service Workers.* [Online] Available at: http://www.sssc.uk.com/registration/do-i-need-to-register/am-i-eligible. [Accessed: 03/08/2017]
[75] Scottish Social Services Council, *Registration timetable*. [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=1485. [Accessed: 27/10/2017]
[76] As shown in the SSSC Annual Report, available at: http://www.sssc.uk.com/annual-report-2012-2013?task=document.viewdoc&id=3235. [Accessed 12/02/18]
[77] Scottish Social Services Council, Code of Practice for Social Service Workers. [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=239. [Accessed: 03/08/17]

- Pay an annual registration fee
- Renew registration every five years
- Carry out PRTL to keep their practice up to date
- Meet the qualification requirements
- Keep the SSSC up to date with their circumstances.

3.60 With regard to qualifications, the SSSC's Registration Rules outline that workers who do not hold required qualifications may, if they meet all the other criteria, be granted registration on the condition that they achieve the required qualifications within the specified period, usually their initial period of registration.

3.61 The SSSC set criteria for qualifications for registration, including that they must:

- incorporate assessment against occupational standards or be based on the assessment of work-based competence
- be designed to match a particular function or range of functions within social services, or meet registration criteria set by a nationally recognised regulatory body
- be subject to a recognised and regulated form of external verification or assessment.

3.62 They assess a range of qualifications against the criteria to see whether they meet their requirements. Those with a qualification that is not on the accepted qualifications list can send in a copy of their award certificate to see whether it meets the requirements for registration[78].

3.63 All social service workers registered with the SSSC have to complete PRTL. The requirements vary depending on the role in question but range between 60 hours and 125 hours of PRTL in a five-year registration period[79].

3.64 If registrants do not meet the requirements laid out in the Code then the SSSC can take action through their fitness to practise process and impose the following sanctions:

- a warning
- conditions
- a suspension

[78] Scottish Social Service Council, *How we assess qualifications*. [Online] Available at: http://www.sssc.uk.com/registration/what-qualifications-do-i-need/how-we-assess-qualifications. [Accessed: 31/10/2017]

[79] Scottish Social Services Council, Post-registration training and learning. [Online] Available at: http://www.sssc.uk.com/registration/registrant-responsibilities/post-registration-training-and-learning. [Accessed: 31/10/2017]

- a combination of either a warning and conditions or a suspension and conditions
- removal from the register[80].

3.65 It is possible for case workers to dispose of cases including taking no further action or imposing any relevant sanction with the agreement of the registrant. If the registrant does not agree with the proposed outcome then the case will go to a fitness to practise panel.[81]

3.66 In 2016/17, there were 171 final fitness to practise decisions made by the SSSC about social care workers, and 80 removals.[82, 83] For the year in question, decisions relating to social care workers constituted just under 90% of all decisions (including social workers).

Northern Ireland

3.67 The Northern Ireland Social Care Council (NISCC) is responsible for regulating the social care workforce in Northern Ireland. Social care managers as well as workers in adult residential homes, nursing homes and children's homes have been required to register since 2011[84] and since March 2017 day care workers, supported living workers and domiciliary care workers have also been required to register with the NISCC.[85] As in the other two countries, registered social care providers are required to employ only workers registered with the NISCC in certain roles.

3.68 Social care workers registered with the NISCC are required to pay an annual registration fee of £30.[86] The NISCC also receives funding from the Northern Ireland Government.[87]

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[80] Scottish Social Services Council, *What is Fitness to Practise?* [Online] Available at: http://www.sssc.uk.com/fitness-to-practise/what-is-fitness-to-practise/about-fitness-to-practise. [Accessed: 31/10/2017]
[81] Scottish Social Services Council, *Information about our investigations*. [Online] Available at: http://www.sssc.uk.com/fitness-to-practise/workers/information-about-our-investigations. [Accessed: 31/10/2017]
[82] 2016/17 data taken from the SSSC website, *Decisions*. [Online] Available at: http://www.sssc.uk.com/fitness-to-practise/hearings-and-decisions/decisions. [Accessed: 15/11/2017]
[83] We have not expressed this as a percentage of the total number of registrants, as this number increased over the course of 2017.
[84] Community Care 2015, *Compulsory registration for domiciliary and day care workers to be introduced in Northern Ireland.* [Online] Available at: http://www.communitycare.co.uk/2015/06/23/compulsory-registration-domiciliary-day-care-workers-introduced-northern-ireland/. [Accessed: 31/10/2017]
[85] Northern Ireland Social Care Council, *Registration & Standards*. [Online] Available at: https://niscc.info/registration-standards. [Accessed: 31/10/2017]
[86] Northern Ireland Social Care Council, *Fees*. [Online] Available at: https://niscc.info/registration-standards/fees. [Accessed: 31/10/2017]
[87] As shown in the most recent NISCC Annual Report, available at; https://niscc.info/storage/resources/20170919_webversion_annualreport_job116245-1.pdf. [Accessed 12/02/18]

3.69 According to the NISCC annual report for 2015/16, at the end of March 2016 there were 17,959 social care workers on the register out of a total of 24,478 which includes social workers and social work students. However, the overall number on the register is due to grow to around 40,000 this year with the ongoing registration of around 15,000 supported living and domiciliary care workers.[88]

3.70 It is an offence in Northern Ireland to employ a person in any of the regulated social care job roles if they are not registered with NISCC. If an employee takes on a role in social care, they must apply for registration as soon as possible. Employers are required to verify an individual's application for registration to confirm they currently work or are due to begin work in a relevant role in social care.[89]

3.71 In order to register, applicants must also demonstrate that they are of good character, good conduct, physically and mentally fit to practise and competent. They must agree to abide by the Codes of Practice for Social Care Workers.

3.72 Currently, registered managers in regulated services are the only group within the social care workforce that have a mandatory requirement to hold one of a range of specific qualifications. Other social care workers are required to be given induction training by their employer within six months of starting work using the NISCC induction standards. The NISCC also provides guidance and advice on any further training and qualifications registrants might want to complete to develop skills and progress their career.[90] All registrants must complete 90 hours of Post Registration Training and Learning in each registration period.[91]

3.73 If a complaint is made against a social worker then they may be taken through the NISCC's fitness to practise process. If the case is not closed and the registrant admits the allegation there is the option for consensual disposal of cases by case officers which may include issuing a warning, agreeing undertakings with the registrant or removal by agreement from the Register.

3.74 A case may be referred directly to a Fitness to Practise Committee based on the findings of another regulatory body e.g. the Nursing and Midwifery

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[88] *The annual report and accounts of the Northern Ireland Social Care Council*. [Online] Available at: https://niscc.info/storage/resources/20160926_job102900_nisccannualreport_highres.pdf. [Accessed: 31/10/2017]

[89] Northern Ireland Social Care Council, Registration & Standards. [Online] Available at: https://niscc.info/registration-standards. [Accessed: 31/10/2017]

[90] Northern Ireland Social Care Council, *Workforce Development and Qualification Guide*. [Online] Available at: https://niscc.info/storage/resources/20161130_workforcedevelopmentandqualificationguide_v2_mh.pdf. [Accessed: 04/08/2017]

[91] Norther Ireland Social Care Council, Post Registration Training and Learning (PRTL) Continuous Learning & Development Standards. [Online] Available at: https://niscc.info/storage/resources/20160704_prtlcontinouslearning_booklet-2.pdf. [Accessed: 31/10/2017]

Council, or the Disclosure and Barring Service, where these findings can be used as evidence. This may also occur where the allegation is based upon a caution or conviction for a criminal offence in any UK Court, or based on a caution or conviction for an offence in another country, which, if committed in the UK, would constitute a criminal offence.[92]

3.75 For the year 2016/17, a total of 33 final fitness to practise decisions were made about social care workers, with 11 removals, from a registrant base of just under 18,000. In the same year, only two decisions were made in relation to social workers.[93]

Views and impact

3.76 The Labour Government in 2008 stated its intention to bring regulation of social care workers, starting with home care workers, within the remit of the General Social Care Council.[94] However, following delays in this process the next Government ruled out statutory regulation of social care staff in England in the white paper Enabling Excellence.[95] It instead highlighted existing systems in place for regulating social care, including the Care Quality Commission's register of providers and the Vetting and Barring Scheme. It also put its support behind a system of assured voluntary registration which ultimately came into being as the Professional Standards Authority's accredited registers programme, but which social care workers are not yet a part of.

3.77 There were mixed views on the Government's decision not to require mandatory registration of social care workers. The UK Home Care Association, which represents providers, was supportive of registration but had raised concerns about the impact of fees on the home care sector and the ability to employ and retain staff. However, service user groups such as Counsel and Care expressed the opinion that older people receiving care at home could be put 'at risk of abuse and poor quality care' due to the lack of regulation.[96]

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[92] Northern Ireland Social Care Council, *Fitness to Practise - How it Works*. [Online] Available at: https://niscc.info/fitness-to-practise-and-hearings/fitness-to-practise-how-it-works. [Accessed: 31/10/2017]

[93] 2016/17 data taken from the Northern Ireland Social Care Council website, *Hearings & Decisions*. [Online] Available at: https://niscc.info/fitness-to-practise-and-hearings/hearings-and-decisions. [Accessed: 15/11/2017]

[94] McGregor, K. *Differences within UK over registration of home care workers*. Community Care 9th November. [Online] Available at: http://www.communitycare.co.uk/2009/11/09/differences-within-uk-over-registration-of-home-care-workers/. [Accessed: 09/11/2017]

[95] Department of Health, *Enabling Excellence - Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. [Online] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf. [Accessed: 03/11/2017]

[96] McGregor, K, 2009. *Differences within UK over registration of home care workers*. Community Care 9th November. [Online] Available at: http://www.communitycare.co.uk/2009/11/09/differences-within-uk-over-registration-of-home-care-workers/. [Accessed: 03/11/2017]

3.78 Although the UK Government took the decision not to go ahead with compulsory registration in England, the devolved nations took a different view. Scotland and Wales initially, followed by Northern Ireland, went ahead with the registration of groups within the social care workforce and have subsequently expanded registration to further groups including domiciliary care workers.

3.79 The Scottish Government consulted on the regulation of health and social care workers in 2004. The majority of respondents were supportive of extending regulation to health care assistants and social care staff, however the transferability of staff across the UK was an issue raised by a number of respondents with a majority in favour of a UK-wide approach to regulation if possible[97].

3.80 The HCPC have outlined a proposal to introduce a system of negative registration for adult social care workers in England. Under the proposals, this group would be subject to a statutory code of conduct and a register would be maintained of those who had been found unfit to practise in the role, however this proposal has not been taken forward by Government.[98, 99]

Initial findings on implications of regulating in fewer than all four countries

3.81 Through our research into the current regulatory framework, and arrangements for pharmacy technicians and social care workers, we have identified a number of emerging issues.

3.82 The picture we describe of regulatory arrangements across the UK is complex. This is in spite of the fact that most professions are regulated UK-wide, either because their regulatory regime predates any devolution settlements, or, for those that do not, because of the way the four UK Governments have chosen to work together. The regulation of social workers and social care workers UK-wide is a helpful example of how an initial government commitment to consistency across the UK can rapidly become eroded if each country has its own regulatory structures and devolved powers.

3.83 In terms of more specific regulatory matters, our research into the regulatory arrangements for social care workers and pharmacy technicians has identified a number of possible risks and issues. We should stress

[97] Scottish Government, *Regulation of health care support staff and social care support staff in Scotland*. [Online] http://www.gov.scot/Publications/2006/05/HCSW. [Accessed 12/02/18]
[98] Health and Care Professions Council, *Proposal for regulating adult social care workers in England*. [Online] Available at: http://www.hpc-uk.org/assets/documents/100049BFHCPCPolicystatement-RegulatingtheadultsocialcareworkforceinEngland(Nov2014).pdf. [Accessed: 03/11/2017]
[99] The Authority was commissioned to look at the feasibility, risks and benefits of negative registers, sometimes known as prohibition order schemes, by the Department of Health. Our report is available here: https://www.professionalstandards.org.uk/docs/default-source/publications/feasibility-of-prohibition-order-schemes---initial-evaluation.pdf. [Accessed 12/02/18]

though that there was a remarkable lack of research evidence relating to the impacts of these regulatory policies.

3.84 We identified a potential risk of practitioners who have been struck off, or who are subject to other sanctions in regulated jurisdictions, seeking employment in similar roles in unregulated jurisdictions. A number of factors may determine whether this theoretical risk is likely to materialise as an actual risk of harm:

- The extent to which practitioners are able or willing to move to another part of the UK[100]
- The level of awareness among employers of regulatory arrangements in other parts of the UK
- Whether employers carry out other checks, such as disclosure and barring checks and employer references, and
- The extent to which these checks are likely to highlight the issues that were identified by the regulator.

3.85 We will discuss these points in more detail later in the report. It is worth noting however that, if this were an actual risk, it would be one that existed already for any groups that were unregulated across the UK. The act of introducing regulation to one jurisdiction but not another would not therefore create a new risk in the unregulated areas. It would merely reduce, or could be perceived to reduce, the risk in the parts of the UK where regulation was being introduced.

3.86 There also does not appear to be a mechanism for regulators to pick up on issues of poor performance or misconduct from prior employment in unregulated areas, aside from the standard criminal record and background checks. This risk can also be mitigated by the use of declarations of good character at registration, and the option – and threat – of taking the registrant through fitness to practise proceedings if issues subsequently come to light. We note that this is not a problem exclusively in relation to workers moving within the UK – regulators of any group that is not universally regulated have only limited means of checking the background of practitioners moving from unregulated jurisdictions worldwide. Again, we should emphasise that this would not strictly speaking be a new risk – the existing risk would merely be emphasised by the introduction of regulation in another part of the UK.

3.87 A number of possible negative impacts would affect practitioners in unregulated areas, and are related to the perceived advantages of statutory regulation. Practitioners in unregulated areas might be considered by the public, employers, or practitioners themselves as having a lower status than those that were regulated. This could stem from the perceived lack of enforced minimum entry requirements, coupled with the absence of

[100] We will consider the question of the geographical mobility of practitioners in more detail later in the report.

protected titles, for example; or it could be down to the fact that regulated practitioners were required to meet standards of continuing fitness to practise, while those who were not regulated had no equivalent requirements. Whether this was in fact the case would depend on the particular circumstances of the occupation, for example whether the group was on a non-statutory register and whether it was accredited by the Authority, or on their circumstances of employment.

3.88 In addition, there is the potential for confusion among both employers and the public about who is regulated where, what they are qualified to do, and what the requirements are for education and training. Our research also identified concerns relating to the transferability of qualifications and possible impact on movement of workers around the UK.

4. Constitutional, regulatory, and other legal issues

4.1 This section looks in detail at the constitutional, regulatory and legal issues that might need to be addressed when considering the introduction of regulation for a group in fewer than all four UK countries. It draws primarily on the legal advice we sought as part of this project,[101] but also on our interviews and the desk research.

Reserved or devolved?

4.2 The regulation of most existing health professions is a reserved matter, meaning that the power to legislate lies with the UK Parliament in Westminster.[102] Regulation of a group is reserved if it falls under the Acts listed in the Scotland Act 1998 (with certain exceptions).[103] These Acts, as listed in the Scotland Act are:

- The Pharmacy Act 1954,
- The Professions Supplementary to Medicine Act 1960,
- The Veterinary Surgeons Act 1966,
- The Medical Act 1983,
- The Dentists Act 1984,
- The Opticians Act 1989,
- The Osteopaths Act 1993,
- The Chiropractors Act 1994, and
- The Nurses, Midwives and Health Visitors Act 1997.

4.3 Some of these Acts have been repealed, but the reservation still stands: it continues to apply for any groups that were regulated at the time of Royal Assent of the Scotland Act.

4.4 This means that for new groups being regulated, power to legislate would be reserved if they appeared to be part of the professions covered by these Acts (again, as they were at the time of Royal Assent of the Scotland Act). For distinctly 'new' professions, on the other hand, regulation would be a devolved matter. This is already the case for seven of the 31 healthcare professions regulated by statute in Scotland, and will likely increase as new groups are added.[104]

[101] The legal advice itself is subject to legal privilege and therefore will not be published.
[102] See table in Annex C.
[103] See legal advice for more detail.
[104] See http://www.gov.scot/Resource/0051/00515284.pdf. [Accessed 06/02/18].

4.5 However, even for reserved matters, Westminster will, under the Sewel convention, seek the consent of Scottish Parliament to the passing of the legislation by Westminster, if it touches on areas of law that are devolved to the Scottish Parliament – as is frequently the case. This convention has a legislative basis in section 28(8) of the Scotland Act, however the Supreme Court has determined that it is not enforceable as a matter of law.[105]

4.6 If a profession were to be regulated in Scotland only, it would be likely, and sensible, for the matter to be devolved, although consideration would need to be given to whether regulation might in future be extended to other countries. If, on the other hand, regulation were to apply to England only, for example, the legislation would be passed by the UK Parliament as there is no devolved legislature for England. The matter would be discussed with Scottish Government, and could be subject to scrutiny by the Scottish Parliament, if any of the provisions were considered to apply in Scotland, even if the matter was not technically devolved, and the Sewel convention did not apply. If a group were to be regulated in England only by amendment to existing legislation, careful drafting would be required to establish the geographical extent of the provisions.

Fitness to practise

Public safety concerns

4.7 We touched on the two main issues relating to fitness to practise and public safety in the previous chapter. Firstly, there is no immediate impediment to a professional who has been struck off, or is subject to a sanction in the regulated jurisdiction, continuing to practise unrestricted in parts of the UK where the role is not regulated. This is an issue that came up in our interviews with stakeholders for the project – but we heard of only one known case, which was a SSSC registrant subject to an interim suspension order finding work in England.[106] What is clear is that good communication with the public and employers in particular about regulatory arrangements across all UK countries is important. This was apparent when we spoke to a colleague from children's services in an English county council bordering Scotland, and it became clear that they were unaware of arrangements in Scotland for regulating social care workers. They therefore did not check the register in Scotland before employing an individual in a social care role, despite their proximity to the border with Scotland – although they did seek Disclosure and Barring Service checks and employer references. In addition, cooperation between professional regulators in one country, and system regulators in another where there is no professional equivalent is also valuable. There is clearly more that could be done here by governments and regulators to protect the public in unregulated areas, by

[105] See: *R (Miller) v Secretary of State for Exiting the European Union 2017 [UKSC] 5.*
[106] We understand that the SSSC had made attempts to alert the English Authorities, but without success.

raising awareness of regulatory arrangements elsewhere in the UK, and facilitating cooperation between regulators across borders.

4.8 Conversely, there is no single formal mechanism for a regulator to pick up on conduct or performance issues from previous employment in an unregulated area, aside from a criminal records check, and possibly evidence of good standing or employer references. Declarations of good character are standard at registration and renewal across UK regulators – this would be another way of bringing to light any concerning acts or behaviour committed in other UK countries. In any event, policy-makers will need to decide on the status of such acts, whether committed prior to the introduction of regulation, prior to registration of an individual, or after they have registered. Fairness to the registrant will need to be considered, particularly with regard to retrospective action for acts that could not have had an impact on the individual's registration at the time they were committed.

4.9 Whether either of these two scenarios is a risk in practice, and not just in theory, is likely to depend at least in part on the level of geographical mobility of the workforce. We can speculate that this may be linked to socio-economic characteristics – we caution though that individuals intent on taking advantage of what they may see as a loophole might constitute outliers in this respect. We were told both by Unison Scotland and the SSSC that home care workers and care at home workers in Scotland would be unlikely to move for their jobs, because of their limited economic means (linked to low salaries), and demographic make-up (large proportion of women in higher age groups). We also consider it likely that an individual's determination to pursue a career in another jurisdiction, despite having been or being subject to regulatory sanctions elsewhere, may be linked to their level of personal and financial investment in that career path – however, evidence on this topic is scant.

4.10 Although we found no research on the link between regulation and mobility of professionals *within* the UK, a study by Maria Koumenta *et al*. looked, among other things, at the impact of professional regulation on mobility in the EU, which is relevant here. [107] The researchers speculated that regulation was likely to act as a deterrent to movement where there was no reciprocal recognition of qualifications, or where the absence of regulation in the destination country might result in a wage penalty.[108] Certainly the findings from their research support the corollary to this theory: they suggest that mutual recognition is encouraging movement between regulated jurisdictions, and is therefore effective at counteracting any such deterrents.

[107] Maria Koumenta, Amy Humphris, Morris Kleiner, Mario Pagliero for the Department for Business, Innovation and Skills, July 2014. *Occupational Regulation in the EU and UK: Prevalence and Labour Market Impacts, Final Report*. Available at: https://www.gov.uk/government/publications/occupational-regulation-in-the-eu-and-uk-prevalence-and-labour-market-impacts. [Accessed 12/02/18]

[108] See our discussion on the impact of regulation on wages in the following chapter.

4.11 While we cannot rule out the possibility that an individual who has been struck off, or is subject to a sanction in a regulated jurisdiction might cross a border to find work elsewhere unchecked, we have found only one example of this happening in practice among our two precedent professional groups. Such behaviour might be more likely if we were considering higher-paid roles, with higher qualification requirements, and therefore greater levels of personal and financial investment in that role.

4.12 As for the chances of an individual moving in the opposite direction – from an unregulated to a regulated area – to escape some past wrongdoing, this is very difficult to assess. As we explained in the previous chapter, we would expect that checks carried out by the regulator would mitigate this risk as far as possible for applicants coming from *any* country in which the role was not regulated. In reality, it is likely that levels of cooperation and familiarity between UK institutions will be higher than with institutions outside the UK, so safeguards are probably more effective for applicants from elsewhere in the UK than for international applicants.

4.13 We should stress though, as we mentioned previously, neither of these two risks, if they are actual risks as opposed to purely theoretical, would be created by the introduction of regulation, strictly speaking. Introducing regulation to one country but not another would merely highlight any risks that existed previously across the UK.

Defining extent and jurisdiction for registration and fitness to practise

4.14 The introduction of regulation of a group in fewer than all four UK countries would need to start with a decision about how to define geographical jurisdiction – in most cases making use of a protected title or protected act, based on a geographical characteristic. While this may seem straightforward on the face of it, it is worth considering the situation in border areas where complexities are more likely to arise, for example with a practitioner living in Carlisle and working in Dumfries.[109]

4.15 Broadly speaking, the geographical extent of registration can be defined in one of two ways:

- place of residence, or
- place of work.

4.16 Using place of residence could lead to the perverse situation in which one professional working in Dumfries was regulated because he or she lived in England, but their colleague was not because they lived in Scotland. Place of work is therefore a more logical option, but also not without its own complications. We note that this is how jurisdiction is defined for the

[109] This example has been used in our legal advice.

regulation of social care workers and pharmacy technicians, and is the proposed basis for the regulation of nursing associates.[110]

4.17 Complications include how to determine where to hold a hearing, if the group is regulated in more than one UK country – this is usually based on place of residence rather than work. Perhaps more problematic is determining the jurisdiction in which a registrant would be entitled to appeal a regulator's decision to refuse registration or take fitness to practise action. If this is based on where the registrant works, for a registrant who crosses a border to work this means they cannot appeal decisions in their 'local courts'. If, on the other hand, registrants can only appeal to courts in the country where they reside, this is an impact on the court system in a country outside the regulatory jurisdiction. The latter option would also be open to challenge about the legal approach to be taken by the courts. On balance, if it was clearly set out in legislation, keeping hearings and appeals in the jurisdiction in which the individual's practice is regulated would be the preferred option.

4.18 The question of which rules of evidence to use in fitness to practise hearings would also need to be settled. This is not as simple as it may first appear. Again, using the example of a practitioner living in one jurisdiction and practising, subject to professional regulation, in another, the registrant may expect the rules of evidence from their country of residence to apply, particularly if the case relates to events that took place in their country of residence. In addition, it would need to be decided whether any powers to require disclosure of information could or would have any force outside the country or countries in which regulation was being introduced. If regulation were being introduced through UK legislation, such powers would be presumed to apply across the UK. Conversely, there would be nothing to prevent devolved legislation from extending the territorial extent of powers to require disclosure to other UK countries, but whether this had any force in practice would depend on whether the local courts allowed it to be enforced. In any case, any such powers might need to be complemented with memoranda of understanding with regulatory bodies in other countries.

Education and recognition of qualifications

4.19 If the regulator is to have powers to approve qualifying training courses, as is standard among the regulators we oversee, thought will need to be given to whether the regulator would have powers to approve courses outside the country in which regulation was being introduced. This would not be unusual, and would not require legislation to be passed in these other countries. The Scottish Qualifications Authority accredits courses provided in England and Wales. On a more global scale, some regulators, such as

[110] See the Government consultation on the draft section 60 Order amending the NMC legislation to incorporate nursing associates, section 10(c): "*to practise as a nurse in the United Kingdom, or as a nursing associate in England*". Available at: https://www.gov.uk/government/consultations/regulation-of-nursing-associates-in-england. [Accessed 12/02/18]

the GPhC and the Solicitors Regulation Authority accredit courses outside the UK, in Malaysia and Germany respectively.

4.20 Decisions would also need to be made about recognition of qualifications obtained in other UK countries. The three social care councils in the UK classify UK nationals as 'exempt persons', a term that is also used to describe individuals qualified in the European Union (EU) and European Economic Area (EEA). This means that they are entitled to register subject to a review by the regulator of their prior qualifications, and possible requirement to undertake additional training. Our legal advice did not identify any issues with this approach.

4.21 Alternatively, policy-makers could create a new category for UK applicants that would enable the regulator to accept applications on a less formal basis than it does for EU/EEA applicants. This could mean recognising certain qualifications or prior experience beyond what might be done for EU or overseas applicants. We note that the addition of this new category would be relatively straightforward if introducing new legislation, but somewhat more complex if amending existing legislation.

Protection of title and use of codes

4.22 The criminal jurisdiction for the prosecution of protection of title or task would need to be determined. Policy makers would need to decide whether it would be considered an offence in one country to carry out a protected act or hold out as a registered member of a profession that was regulated in another.

4.23 Our legal advice indicates that it would be unlikely for a title to be protected outside the country in which regulation was being introduced. This would mean though that the protected title could be used in other countries as a simple job title. Some thought might therefore need to be given to distinguishing between the job title in one country and the protected title in another. The protected title could include the name of the country in which it was regulated, and/or the term 'registered'. As with the fitness to practise issues described above, efforts would need to be made to raise awareness of regulatory arrangements in general, and protected titles in particular, across the UK, in both regulated and unregulated jurisdictions.

Interaction with other legislation

4.24 Finally for this chapter, there are a number of issues that may arise relating to interactions with existing legislation.

Human rights

4.25 The introduction of regulation of a pre-existing role has the potential to infringe an individual's human rights if it affects their ability to remain in their current job. This engages Article 1 of the First Protocol of the European Convention of Human Rights, which extends to a person's right to exercise a profession. This right can however be infringed if it is in the public interest

and individuals are given a fair opportunity to transfer to the new regulatory arrangements – usually in the form of transitional arrangements known as 'grandparenting'.

4.26 The introduction of regulation in fewer than all four countries therefore raises the interesting question of how to justify such a human rights infringement on public interest grounds in one UK country, if it is not deemed necessary in another. Our legal advice suggests that the fact that each country has its own democratic basis (elected Parliament/Assembly) could provide an argument to support separate assessments of the public interest. This has yet to be tested in the Courts however.[111]

EU and UK competition law

4.27 Our legal advice concluded that EU competition law would not apply between different parts of the UK in the same way as it would between two EU member states. In addition, any new legislation creating a new profession to be regulated would trump existing UK competition law.

Interaction with existing regulators

4.28 There is some cross-referencing between regulatory legislation. We note in particular that General Medical Council (GMC), NMC, General Dental Council (GDC) and HCPC registrants are not required to be registered with the SSSC if they wish to register as a social services worker in Scotland. Should any of these regulators take on a new profession, those registrants would also be exempt. This is an issue to be monitored and addressed by the regulator and/or the Parliament that owns the legislation in which the cross-reference appears, however, rather than the regulator or Parliament that owns the legislation which is being referred to. In the above example, it would be for the Scottish Government or SSSC to review and amend its legislation as necessary.

In conclusion

4.29 Our legal advice did not identify any insurmountable issues. However, it did identify a number of areas of complexity to which careful thought would need to be applied. We note that many of the issues and complications arise where there is interaction between nations, and are exacerbated where regulation is being introduced by amending existing legislation rather than creating new legislation. The primary public safety concern relates to workers crossing borders to escape the consequences of an egregious act. Whether this would manifest in practice is hard to ascertain, but may be linked to the level of personal investment in a career path, and socio-economic and demographic predictors of geographical mobility.

[111] In the next chapter, we present an argument for the use of different regulatory arrangements in different countries based on our risk assessment model, *Right-touch assurance.*

5. Unintended consequences

5.1 In the previous chapter, we identified a number of constitutional, regulatory and legal issues associated with the introduction of statutory regulation to one UK country but not another. In this chapter we consider the broader potential impacts on professionals, the workforce, and availability of workers, in both the short and the long-term. Our interviews with stakeholders and our desk research suggest that there has been little impact on the workforce UK-wide, from the regulatory arrangements for pharmacy technicians and social care workers. We have therefore looked to international research evidence, and the USA in particular. This is because its federal structures have led to significant variations in how professions are regulated. The research we have used often covers professions not just in health, but also across a number of different sectors.[112]

Consequences of a single decision to deviate from a four-country approach

5.2 The decision to regulate *any* group, whether across an entire nation or in a partial jurisdiction is likely to have a number of impacts in the regulated areas, that need to be taken into account when deciding whether and how to regulate.[113] For the purposes of this report, we must also consider the possible impacts in unregulated areas and any possible jurisdictional frictions. We stress that this is a complex topic, with many possible variables, and an almost infinite number of possible scenarios – for the purposes of this report, we have covered only the key points.[114]

5.3 The introduction of regulation is often believed to have a number of benefits for the workforce, in addition to protecting the public or consumers:

- Raising standards of entry to the profession through minimum entry requirements and option of quality assurance of education courses
- Raising standards of practice throughout a professional's career by setting and enforcing standards of continuing fitness to practise
- Excluding from the profession those that fail to meet the standards

[112] While there is much research published on the impact of introducing regulation on the workforce and markets in the jurisdictions where it is introduced, we found little evidence charting the impact on areas where regulation is absent.

[113] *Right-touch assurance,* our theoretical model for risk assessment of an occupation, takes into account some of these unintended consequences. Available at: https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm. [Accessed 12/02/18]

[114] . For a more comprehensive study and discussion of the possible impacts on markets of the introduction of regulation in different forms, we recommend this report by the UK Commission for Employment and Skills (UKCES) on the impact of occupational regulation: UK Commission for Employment and Skills, 2011. *A review of occupational regulation and its impact.* Available at: https://www.gov.uk/government/publications/occupational-regulation-a-review. [Accessed 12/02/18]

- Removing from the profession those that fall below the required standard
- Raising the status of the profession
- Increasing the pay of the registrants.

5.4 In this section we consider how these apparent benefits for members of the profession can have negative impacts elsewhere.

Barriers to entry

5.5 That statutory regulation creates a barrier to entry to an occupation by introducing entry requirements is both self-evident and amply demonstrated in the literature.[115] For low-paid roles in particular, the introduction of regulation may exacerbate an existing problem: healthcare providers are already competing with alternative low-paid roles in any given area. Introducing barriers to entry is likely to push potential recruits to other jobs that are simply easier to obtain. For example we heard in our interviews that social care providers in England are often competing with local supermarkets to recruit and retain staff with a workforce that is notoriously transient – and we have found some research evidence to support this.[116, 117]

5.6 There is also evidence that, in Europe at least, regulation acts as a barrier or a deterrent to entry to a profession for migrant workers. Research conducted on professions in the EU by Maria Koumenta *et al.* found that immigrants, and particularly those from outside the EU, were less likely to enter regulated than unregulated occupations in the UK. [118]

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[115] See for example, these two studies of the effects of occupational licensing across the USA, one by Carpenter D *et al*. for the Institute for Justice, available at http://www.ij.org/images/pdf_folder/economic_liberty/occupational_licensing/licensetowork.pdf [Accessed 12/02/18], and another for the Obama Administration by the Department of the Treasury Office of Economic Policy, the Council of Economic Advisers, and the Department of Labor, available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf [Accessed 12/02/18]

[116] According to the most recent report from Skills for Care on the State of the Adult Social Care Workforce, the turnover rate for directly employed staff in adult social care was 27.8% for 16/17. For more information, see: http://www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC/Workforce-data-and-publications/State-of-the-adult-social-care-sector.aspx. [Accessed 12/02/18]

[117] See for example this study of the challenges in meeting demand for domiciliary care in Somerset carried out by Sheffield Hallam University. Yeandle S. Shipton L., and Buckner L. for Somerset County Council, 2006*. Local Challenges in Meeting Demand for Domiciliary Care in Somerset.* Available at: http://www4.shu.ac.uk/_assets/pdf/ceir-S7DomCareSomerset_100706.pdf. [Accessed 12/02/18]

[118] Maria Koumenta, Amy Humphris, Morris Kleiner, Mario Pagliero for the Department for Business, Innovation and Skills, July 2014. *Occupational Regulation in the EU and UK: Prevalence and Labour Market Impacts, Final Report*. Available at: https://www.gov.uk/government/publications/occupational-regulation-in-the-eu-and-uk-prevalence-and-labour-market-impacts. [Accessed 12/02/18]

5.7 In addition, research suggests that regulation is often associated with an increase in earnings, ranging from 1.7% to 19% – the Koumenta research found that this applied to dentists (13.7%), pharmacists (9.5%), architects (8.7 %), accountants (19.1%) and less significantly to security guards (1.7%), but not to teachers, social workers, or plumbers.[119] The extent of this wage premium appears to be positively linked to the length of time an occupation has been regulated and the level of educational requirements. Research from the US also suggests that wage premiums are more closely associated with regulation of groups that deal directly with consumers and with those that work independently of other regulated professions.[120]

5.8 Wage premiums are a double-edged sword however, and perhaps for this reason we have not seen them used as an explicit argument in favour of regulation. In particular, they could create a barrier to access to services, whether provided through the resource-limited NHS, or directly to patients through private practice. The cause of this wage premium is not identified in the research, but it seems likely that it has to do with simple economics: barriers to entry to the labour market restrict the supply of a service, leading to a reduction in competition and enabling prices to increase. It may also be linked to a perception of improved quality, if not an actual improvement.

5.9 What these barriers might mean for parts of the UK in which a group is not regulated is difficult to assess. There is little evidence of any such impact from the arrangements for pharmacy technicians or social care workers – but there is a theoretical possibility that regulation could attract 'higher calibre' workers, resulting in a 'brain drain' from the areas where the group is not regulated. Whether this would be likely to manifest would no doubt depend on the geographical mobility of two groups: those practising the occupation, or equivalent, in unregulated areas, and those who might be attracted to it as a new career path. We explained in the previous chapter that such forms of mobility are linked in part to socio-economic characteristics – low-earning occupations would therefore be less likely to follow these sorts of migration patterns than high-earning ones. That said, the lure of a higher salary elsewhere in the UK, even if relatively low, could be enough for some to overcome any such socio-economic barriers.

5.10 Creating barriers to access to a service or practice could also result in some patients or clients, particularly those living in border areas, seeking care in unregulated areas. This would be the case only for non-NHS care though, and only if, in the eyes of the consumer, regulation did not bring with it any

[119] Maria Koumenta, Amy Humphris, Morris Kleiner, Mario Pagliero for the Department for Business, Innovation and Skills, July 2014. *Occupational Regulation in the EU and UK: Prevalence and Labour Market Impacts, Final Report*. Available at: https://www.gov.uk/government/publications/occupational-regulation-in-the-eu-and-uk-prevalence-and-labour-market-impacts. [Accessed 12/02/18]

[120] UK Commission for Employment and Skills, 2011. *A review of occupational regulation and its impact.* Available at: https://www.gov.uk/government/publications/occupational-regulation-a-review. [Accessed 12/02/18]

guarantees of quality or safety that outweighed the cost premium. We would estimate this impact to be minimal in any case.

Perceptions of quality and risk of harm

5.11 The evidence that regulation in itself necessarily improves the quality of services or practice is mixed. Some studies suggest that the introduction of regulation has little effect on quality,[121] and particularly in healthcare, it is challenging to demonstrate effects on quality of care and patient outcomes. But there are studies that show a positive impact on factors that can be reasonably linked to quality. These might be the level of skill required to enter a statutory register,[122] or the requirements relating to continuing fitness to practise, which if nothing else, can coerce or influence employers to improve their performance monitoring and appraisal systems.[123] We note that the impact of both these factors is likely to depend on the extent and shape of the regulatory requirements.

5.12 In any event, the idea that regulation improves standards of practice, whether real or assumed, could have an impact on practitioners in parts of the country that are not subject to regulation. Our research into the arrangements in the UK for pharmacy technicians found a perception among some members of the profession itself that standards of practice were higher in regulated areas. We also know this to be the case from our own experience of seeing groups petitioning for statutory regulation to achieve this aim, along with what they believe will be an enhanced professional status.

5.13 The introduction of regulation also puts in place 'new' safeguards to limit the chances of unsuitable, and possibly dangerous individuals from entering the profession, by requiring criminal records checks and/or other types of background checks. Whether these measures make a difference to public safety is likely to depend on what systems were in place before, particularly employment practices, and how effective they were.

5.14 In the absence of sound research evidence, we can nevertheless speculate that these features of regulation could have the following impacts in parts of the UK where a group is unregulated:

- The devaluation of the practice or services provided by similar or equivalent occupations, in the eyes of the public, employers, practitioners, or aspiring practitioners

[121] Kleiner M, University of Minnesota, 2017. *The influence of occupational licensing and regulation*. IZA World of Labor 2017: 392 doi: 10.15185/izawol.392. Available at: https://wol.iza.org/articles/the-influence-of-occupational-licensing-and-regulation/long. [Accessed 12/02/18]

[122] UK Commission for Employment and Skills, 2011. *A review of occupational regulation and its impact.* Available at: https://www.gov.uk/government/publications/occupational-regulation-a-review. [Accessed 12/02/18]

[123] See, for example, research into the impact of introducing revalidation for doctors in the UK, available at: http://www.gmc-uk.org/news/28650.asp. [Accessed 12/02/18]

- The assumption that the arrangements for quality assurance and public safety are inadequate, or at least less robust than under statutory regulation
- The perception that the occupation is 'high risk', that it is likely to cause harm.

5.15 These could in turn lead to a reluctance by employers or patients and clients to draw on the services of these groups. That said, we saw no evidence that this was the case in practice, either in Northern Ireland with pharmacy technicians, or in England with social care workers, in our desk research or our interviews. It may be that the economic advantages of a group not being regulated – namely the absence of a wage premium – and the need to fill posts outweigh any of the above concerns. In any case, any loss of public confidence in a role, if it came to pass, could be addressed through communication about how existing mechanisms can mitigate any risks, and how quality of care is maintained.

Justifying differences in approach

5.16 Perhaps more problematic, for governments at least, is how to justify and explain the introduction of regulation to one part of the UK but not another, if two governments disagree on the need to regulate.[124] In our view, such a difference of position is justifiable in some circumstances, but it needs to be underpinned by a coherent narrative about the purpose of regulation and the reasons why it was needed in one country but not another.

5.17 *Right-touch regulation* advocates for regulation to be used only when it is necessary to address the risks of harm presented by the profession, taking into account any existing mitigations.[125] Our occupational risk assessment model, *Right-touch assurance*, explains how this can be done when considering whether and how to regulate a group.[126] Of particular relevance here is that it builds consideration both of intrinsic contextual factors relating to the environment in which an occupation practises, and subsequently of any existing mitigations, such as employer-led assurance models, into the assessment of risk.

5.18 We are aware of the growing differences in approach across the UK to healthcare provision, workforce development, and employment practices. One example is the development of an employer-led model of assurance for

[124] This is linked to a point in the previous chapter, where we explained that governments may have to justify any infringement on the right to exercise a profession that regulation entails, and that this could be open to challenge if not applied across the UK.
[125] Professional Standards Authority, 2015. *Right-touch regulation – revised.* Available at: https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation. [Accessed 12/02/18]
[126] Professional Standards Authority, 2016. *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*. Available at: https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm. [Accessed 12/02/18]

health care support workers in the NHS in Scotland;[127] another is the announcement that a new nursing support role, nursing associates, would be introduced in England, and regulated by the NMC.[128] It would seem, therefore, arguable that different approaches to professional regulation could be adopted – if the problem was being considered exclusively on a risk basis, and the outcome of the risk assessment identified different levels of risk in different countries. This might be the case if the role being assessed was materially different, perhaps through significant differences in the scopes of practice or in the practice setting, or if there were existing mitigations in one country but not another.

5.19 This is in fact the current position on the expansion of professional regulation of the UK Government, which was set out in the 2011 Command Paper, *Enabling Excellence*.[129, 130] Here, it was explicitly stated that regulation of any new groups must be based on a risk assessment:

> *'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.'*[131]

5.20 This position is restated in a recently published four-country consultation, which proposes that *Right-touch assurance* should be used as a means of assessing whether and how to regulate a particular group.[132]

5.21 While we are fully supportive of this approach, we note a possible tension with the current four-country commitment to UK-wide regulation. It is likely that a risk-based approach would in certain circumstances justify different approaches across the four UK countries, for the reasons explained above. What decision-makers will need to determine under such circumstances is whether the arguments in favour of a UK-wide approach outweigh the

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[127] See the NHS Education Scotland website for more information: http://www.hcswtoolkit.nes.scot.nhs.uk/hcsw-standards-and-codes/hcsw-code-of-conduct/. [Accessed 12/02/18]

[128] See this summary of Jeremy Hunt's announcement, November 2011: http://www.nhsemployers.org/news/2016/11/jeremy-hunt-workforce-announcements. [Accessed 12/02/18]

[129] Although published under the previous Government, this Command Paper has yet to be superseded, and therefore still stands as Government policy.

[130] Department of Health, 2011. *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. The Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf. [Accessed 12/02/18]

[131] Department of Health, 2011. *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. The Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf. [Accessed 12/02/18]

[132] Department of Health, October 2017. *Promoting professionalism, reforming regulation.* Available at: https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation. [Accessed 12/02/18]

benefits of a risk-based approach. When considering the pros and cons of UK-wide regulation, they will want of course to consider the complexities of introducing regulation to fewer than all four UK countries, in addition to any unintended consequences, as set out in this report.

Longer-term unintended consequences

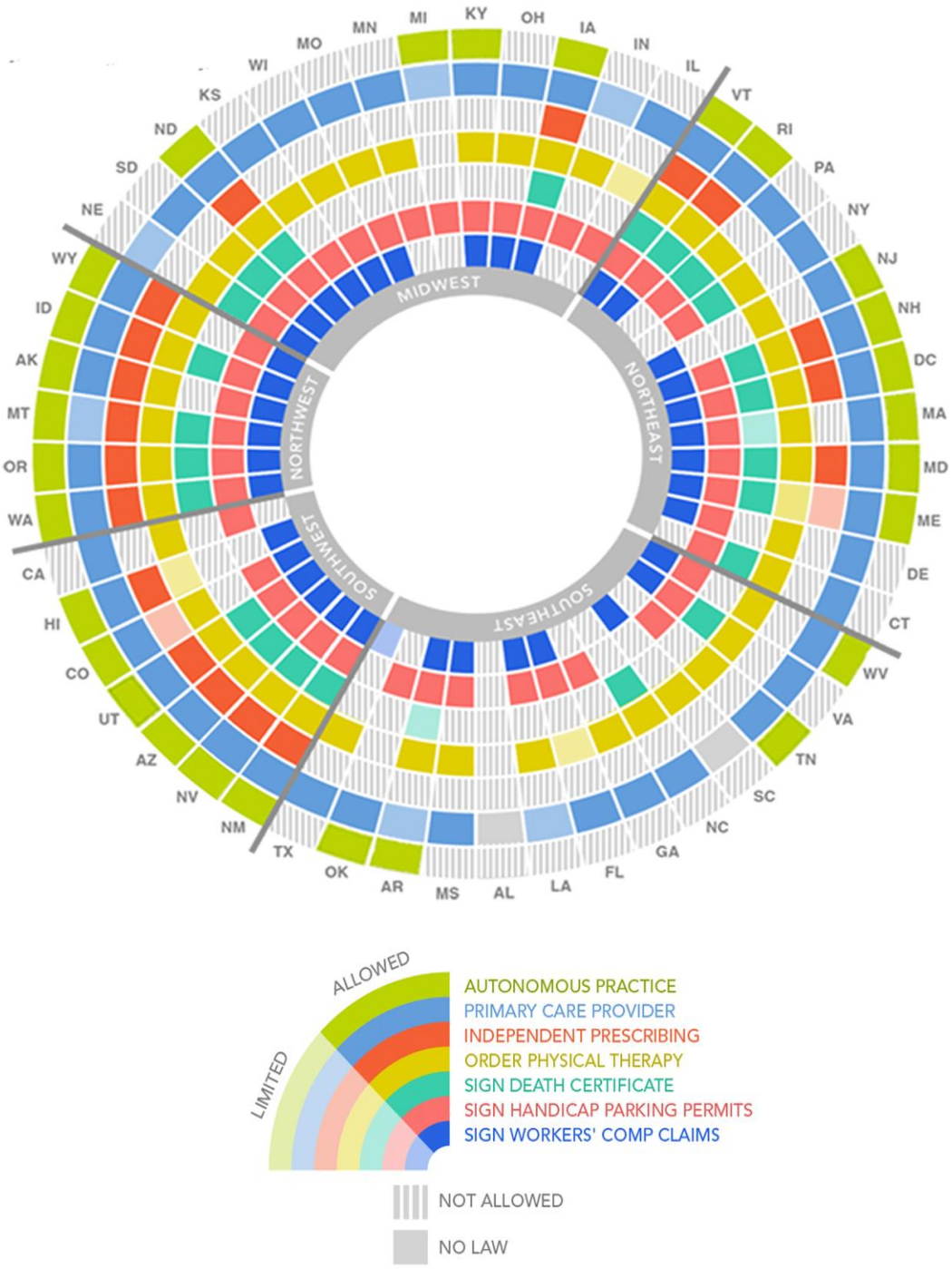
5.22 We caution that the long-term impacts of deviating from a UK-wide approach may be significant. Extreme examples can be seen in federal countries, such as the USA and Canada. Over time, scopes of practice diverge, and mutual recognition of roles between jurisdictions becomes increasingly difficult, with consequent impacts on the mobility of workers. This phenomenon is widely recognised, and described in several of the research pieces referred to above, including work by Morris Kleiner,[133] and the joint report for the Obama Administration on the impacts of occupational licensing.[134] It is also strikingly illustrated by Figure 1, which shows the different scopes of practice for nurse practitioners across the different US States. It is worth noting that the barriers to mobility between jurisdictions are higher where differences in entry requirements are more marked. For lower-skilled occupations, for whom additional training or experience may be gained relatively quickly and cheaply, the impact on movement is likely to be less significant.

[133] Kleiner M., 2015. *Guild-ridden labor markets: the curious case of occupational licensing.* Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. Available at: https://doi.org/10.17848/9780880995023. [Accessed 12/02/18]

[134] Department of the Treasury Office of Economic Policy, the Council of Economic Advisers, and the Department of Labor, 2015. *Occupational Licensing: A Framework for Policymakers*. Available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf. [Accessed 12/02/18]

Figure 1: Scopes of practice for nurse practitioners across the US States

Source: Barton Associates. For an interactive version of this chart, see https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws/. [Accessed 12/02/18]



5.23 There are also risks to public and employer understanding and confidence, if the already complex regulatory landscape in the UK becomes more fragmented. We heard in our interviews that awareness of regulatory arrangements for social care workers in Scotland was low in the local authority we spoke to. Patients and service users, who may well seek treatment or care in different parts of the UK throughout their lives, may also be understandably confused.

5.24 As devolution evolves we can see that initial commitments to UK-wide approaches can become harder to maintain, particularly if no longer supported by shared institutions. This is amply illustrated by the example of regulatory arrangements for social care workers in the four countries. Because healthcare planning and provision is a matter that is devolved to Wales, Scotland, and Northern Ireland, we predict that there will be an increasing number of situations in which this tension between UK-wide agreements and risk-based regulation will come to the fore. However, in the light of the aforementioned longer-term impacts of diverging approaches, we suggest that the current commitment to UK-wide regulation of healthcare professionals is maintained, but with an opt-out as follows.

5.25 Regulation of all groups should be UK-wide, unless:

- different approaches between UK countries are justified by the outcomes of an objective and evidence-based assessment of occupational risk, *and*
- the impact of taking different approaches has been assessed as having a minimal impact on workforce supply across the UK, *or*
- measures can be taken that mitigate the impact on supply by facilitating the movement of workers around the UK.

5.26 The second bullet point reflects the fact that the impacts on and need for workforce mobility will vary across different occupations. Such an approach would enable governments to strike a balance between regulating only where necessary to address an identified risk of harm, and maintaining a unified approach to regulation UK-wide, in order to minimise the long-term impacts on the healthcare workforce.

In conclusion

5.27 The unintended consequences of introducing statutory regulation are real but not easy to predict. There is certainly evidence that it can create barriers to entry that have disruptive effects on the job market, and could lead to workforce shortages in the regulated jurisdiction. What this means for the workforce in neighbouring unregulated areas is likely to depend on a multitude of factors, including the role itself, and the socio-economic characteristics of the practitioners. For example, we found no evidence of any particular impacts on the pharmacy technician or social care workforces in other UK countries resulting from the current regulatory arrangements. However, it is possible that occupations with higher levels of geographical

mobility are likely to be more affected, with a risk that more highly-qualified practitioners who meet the entry requirements for registration might be attracted by roles in the regulated area. On the other hand, those who are less qualified might remain in, or move to, unregulated jurisdictions. We cannot however quantify this risk, particularly given the lack of evidence relating to the workforce impacts of introducing regulation in one UK country but not another. This is an area where we would welcome further study – any instance of partial regulation being introduced constitutes a rare research opportunity in this respect.

5.28 A more tangible issue related to introducing regulation in one country but not another, is that of public and employer understanding, confidence, and expectations. There would need to be clear communication with the public, employers, and practitioners themselves about why regulation was being introduced in one country and not another. This would need to be underpinned by a clear narrative about the purpose of regulation and an evidence-base, ideally using an objective and robust occupational risk-assessment model.

5.29 We support the use of risk-based methods for determining the need for regulation, and we accept that such methods could result in different outcomes across the four UK countries – if the role was materially different, or if the mitigations were significantly higher in one country than in another. We caution however that long-term divergence from the commitment to regulate professions UK-wide could have significant impacts over time. What we find in the USA, which is perhaps an extreme example of this, is that the geographical mobility of professionals across the country is significantly reduced by differences in regulatory requirements and scopes of practice between States. We therefore suggest that UK-wide regulation should remain the norm, but that there may be circumstances where risk analysis justifies a deviation from this norm, provided any problematic impacts on workforce supply across the UK can be managed.

6. Conclusion

6.1 The implications of regulating a group in fewer than all four UK countries are complex and varied. The arrangements for pharmacy technicians and social care workers are helpful precedents that demonstrate both that it is possible to legislate for regulation on this basis, and that the impacts and unintended consequences for these two groups are, as far as we can tell, relatively minor. However, what our overview also shows is the complexity that these arrangements add to an already confusing regulatory landscape. The regulation of social care workers in particular was initially intended to be rolled out in a coordinated manner across the UK, albeit by four separate regulatory bodies. As successive Governments have taken over, regulatory policies have now diverged to a point where different groups of social care workers are regulated differently in the three devolved nations, while none are regulated at all in England.

6.2 Our legal advice confirms that legislating for regulation in fewer than four countries is possible, however there are a number of questions and issues that would need to be carefully thought through, such as how to define the territorial extent of different regulatory powers. The main public safety concern would be registrants subject to a sanction crossing the border to work, unchecked, in an unregulated part of the UK. This risk is impossible to quantify, however, and could be mitigated through effective UK-wide communication and awareness-raising about regulatory arrangements across all four jurisdictions, and cooperation between regulators.

6.3 Governments will also need to consider the unintended consequences of such a decision, with a particular focus on the workforce in those areas where regulation is not being introduced. Given the lack of research evidence, it is difficult to predict these sorts of effects without a specific scenario, but we believe they could range from the loss of confidence in an occupation where it is not regulated, to a ‘brain drain’, as the most competent and skilled practitioners move to parts of the UK where the role is regulated, and most likely, better paid. We stress however, that we found no evidence of any such negative impacts for either pharmacy technicians or social care workers, so it is likely to depend on the specific circumstances and characteristics of an occupation.

6.4 With any decision to regulate in one country but not another, governments will need to be able to explain and justify this difference in approach – potentially in a court of law, if challenged. Risk-based regulation, to which the UK Government is committed, and more specifically the use of objective and evidence-based assessments of occupational risk, should in our view be used to decide whether and how to regulate a group. We are aware that this approach could lead to a difference in outcomes across the UK countries, if the roles were materially different, or carried out in different contexts, or if the mitigations in place in one country provided assurances

that did not exist in another. These mitigations could take the form of an employer-led assurance model, for example. We note though that this appears to run contrary to the four-country commitment to regulating healthcare professionals UK-wide, and could, over time, increase the complexity of the regulatory landscape, with consequent effects on public and employer understanding and confidence.

6.5 We caution that dispensing with the current four-country agreement could also have serious implications for workforce movement and supply in the long-term. We looked to the USA for research evidence here, where state-led regulation has resulted in huge variations in scopes of practice. As a result, practitioners are often unable to practise in other states without either undertaking additional training to meet requirements, or losing the right to carry out parts of the role they originally trained for. Both are disincentives to relocating that can disrupt workforce supply.

6.6 The UK's plans to exit the EU, and both current and predicted health and care workforce shortages, point to the need for governments to be alive to any unintended consequences that might affect the supply of workers. We therefore suggest that the four-country commitment to UK-wide regulation should be maintained, but with the addition of an opt-out if an occupational risk assessment suggests taking different approaches across the UK, and there are adequate mitigations for any impacts on workforce supply. Such an approach would enable governments to strike a balance between regulating only where necessary to address an identified risk of harm, and maintaining a unified approach to regulation UK-wide, in order to minimise the long-term impacts on the healthcare workforce.

7. Annex A: Commissioning letter

Chief Nursing Officer Directorate
Fiona McQueen, Chief Nursing Officer

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 2314 F: 0131-244 3465
E: fiona.mcqueen@gov.scot

Harry Cayton CBE
Chief Executive
Professional Standards Authority
157-197 Buckingham Palace Road
London
SW1W 9SP

23 March 2017

Dear Harry,

In accordance with section 26A(1) of the NHS Reform and Health Care Professions Act 2002, I am writing in confidence on behalf of the Cabinet Secretary for Health and Sport to ask the Professional Standards Authority for Health and Social Care (PSA) to undertake a commission as outlined below.

The Scottish Government remains committed to the regulation of healthcare professionals on a four country basis. However, the decision by the Department of Health to regulate Nursing Associates in England raises possible constitutional, legal and regulatory challenges for the future of the professional workforce across the UK.

With the exception of differences to pharmacy regulation in Northern Ireland, I understand that Nursing Associates are the first group to raise the possibility of a unilateral approach and it might be envisaged that further professional groups will continue to emerge, given the increasing divergence of health policy across the four administrations.

In order to fully understand the ramifications of the current and possible developments, I consider it vital that an empirical basis is available, upon which to explore the practical issues and consequences should different approaches be taken across the four countries.

The Scottish Government is interested in commissioning the PSA to undertake research that provides a sound platform for further consideration of relevant issues.

Key areas for research could include but would not be limited to:

- Consideration of issues resulting from practitioners moving between similar roles across borders on a regulated and non-regulated basis, and whether these issues might vary from one group to another and why (for example according to the level of risk);

- Legal issues arising from regulating in only one country or less than all four countries;

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

- A comparison with the approaches to social care worker regulation, which are different in all four countries;

- Any other issues that the Authority considers relevant, and particularly unintended consequences, that might impact on quality of care and outcomes.

We understand that the Authority will retain the intellectual property rights for this work, however given the potential for sensitivities resulting from it, we would require the report to be confidential, and only published with the authorisation of the Scottish Government. In the event that the report is published, reference will be made that it has been commissioned and funded by the Scottish Government.

I would envisage that the final report and its conclusions would inform advice to Ministers and may include the potential for further research. In respect of timescales, I would appreciate the final advice by December 2017 with a timescale for an interim report to be produced at an earlier stage once a project plan has been agreed. However we require notification at the earliest opportunity if there are any delays or if any problems are identified which may delay the work.

In accordance with the Authority's own policy on the commissioning process, we will expect to see a draft of the final report before it is signed off.

I would therefore welcome sight of your costings and draft contract for delivery of this work at your earliest opportunity, with a project plan to follow.

Yours sincerely,

Professor Fiona McQueen
Chief Nursing Officer

8. Annex B: Table 1 – Social care groups regulated in Scotland, Wales and Northern Ireland

	Residential childcare manager	Adult care home manager	Domiciliary care manager	Day care centre/ service manager	Housing support service manager	Children's day care manager	Children's day care worker	Residential childcare workers	Adult residential home worker	Adult nursing home worker	Housing support workers	Domiciliary care workers
England	No	No	No	No	No	No (required to register with Ofsted)	No (required to register with Ofsted)	No	No	No	No	No
Scotland[135]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wales[136]	Yes	Yes	Yes	No	No	No	No	Yes	No	No	No	Registration open from 2018, Welsh Government consulting on mandatory registration from 2020
Northern Ireland[137]	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	Yes

[135] Scottish Social Services Council, *Registration timetable*. [Online] Available at: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=1485 [Accessed: 27/10/2017]
[136] Social Care Wales, *Who has to be registered to practise in Wales?* [Online] Available at: https://socialcare.wales/registration/what-is-registration#section-276-anchor [Accessed: 27/10/2017]
[137] Northern Ireland Social Care Council, *Registration & Standards*. [Online] Available at: https://niscc.info/registration-standards [Accessed: 27/10/2017]

9. Annex C: Statutorily regulated professions, accredited registers of occupations, and other

Table 2: Occupations covered by regulators or accredited registers

N.B: For occupations regulated by statute, regulatory powers are reserved to the UK Parliament, unless it is specified that they are devolved.

All accredited registers can register practitioners across the UK.

Type of assurance	Regulator	Occupation/*other*
Statutory	General Chiropractic Council	Chiropractors
	General Dental Council	Dentists Dental hygienists Dental therapists Clinical dental technicians (*devolved*) Orthodontic therapists (*devolved*) Dental nurses (*devolved*) Dental technicians (*devolved*)
	General Medical Council	Doctors
	General Optical Council	Dispensing opticians Optometrists *Students* *Optical businesses*
	General Osteopathic Council	Osteopaths
	General Pharmaceutical Council (*GB only*)	Pharmacists Pharmacy technicians (*devolved*) *Registered pharmacies*
	Health and Care Professions Council	Arts therapists Biomedical scientists Chiropodists/Podiatrists Clinical scientists Dieticians Hearing aid dispensers

		Occupational therapists Operating department practitioners (*devolved*) Orthoptists Prosthetists/Orthotists Paramedics Physiotherapists Practitioner psychologists (*devolved*) Radiographers Social workers (*England only*) Speech and language therapists
	Nursing and Midwifery Council	Nurses Midwives
	Pharmaceutical Society of Northern Ireland (*Northern Ireland only*)	Pharmacists *Registered pharmacies*
	Scottish Social Services Council *(Scotland only)*	Social workers Social care workers
	Northern Ireland Social Care Council *(Northern Ireland only)*	Social workers Social care workers
	Social Care Wales *(Wales only)*	Social workers Social care workers
Professional Standards Authority accredited registers programme[138,139] ***N.B. all of these registers are voluntary to join. In addition there are a number of other voluntary registers that have either not yet gained or have not sought accreditation.***	Academy for Healthcare Science	Healthcare Science Practitioners working in a wide variety of disciplines, *including*: Physiological Sciences Microbiology Nuclear Medicine Life Sciences Health Informatics Physical Sciences Healthcare Science Haematology

[138] Please note that the occupations listed in this section of the table are not exhaustive for each accredited register, given the large number of modalities and disciplines in some areas.
[139] Two of the accredited registers (Save Face and Treatments You Can Trust) register only people who are also statutorily regulated.

These are listed separately in the next table.		Biomedical Science Biomechanical Engineering Bioinformatics Audiology Anatomical Pathology Technologists Genetic Technologists Ophthalmic Science Practitioners Tissue Bankers Medical Illustration Clinical Physiology Life Sciences
	Alliance of Private Sector Practitioners	*Including*: Foot Health Practitioners
	Association of Child Psychotherapists	*Including*: Psychoanalytic child psychotherapists Adolescent psychotherapists
	Association of Christian Counsellors	*Including*: Counsellors Psychotherapists
	British Acupuncture Council	*Including*: Acupuncturists
	British Association for Counselling & Psychotherapy	*Including*: Psychotherapists Counsellors
	British Association of Play Therapists	*Including*: Play Therapists Counsellors
	British Association of Sport Rehabilitators and Trainers	*Including*: Graduate Sport Rehabilitators
	British Psychoanalytic Council	*Including*: Psychotherapists Counsellors
	Complementary and Natural Healthcare Council	Complementary therapy practitioners

		working in a range of modalities *including*: Sports Therapists Nutritional Therapists Reflexologists Naturopaths Massage Therapists Hypnotherapists Microsystems-Acupuncturists Craniosacral Therapists Bowen Therapists Alexander Technique practitioners Healing practitioners Reiki healers Shiatsu practitioners Yoga Therapists Colon Hydrotherapists Kinesiologists Sports Massage practitioners
	COSCA (Counselling & Psychotherapy in Scotland)	*Including*: Counsellors Psychoanalytic Psychotherapists
	Federation of Holistic Therapists	Complementary Healthcare Therapists working in a range of modalities *including:* Yoga Therapists Sports Therapists Shiatsu practitioners Reiki healers Reflexologists Nutritional Therapists Massage Therapists Naturopaths Kinesiologists Hypnotherapists Homeopaths Craniosacral Therapists Aromatherapists Bowen Therapists

		Acupuncturists Alexander Technique practitioners Healing practitioners Sports Massage practitioners
	Genetic Counsellor Registration Board	*Including*: Genetic Counsellors
	Human Givens Institute	*Including*: Human givens psychotherapists Counsellors
	National Counselling Society	*Including*: Psychotherapists Counsellors
	National Hypnotherapy Society	*Including*: Hypnotherapists
	Play Therapy UK	*Including*: Play Therapists Certified Play and Creative Arts Counsellor of Children and Young People
	Register of Clinical Technologists	Clinical Technologists working in a variety of disciplines*, including*: Renal Technology Radiation Physics Rehabilitation Engineering Radiotherapy Physics Radiation Engineering Medical Engineering Clinical Technology Nuclear Medicine Healthcare Science Clinical Science
	Save Face	*Including*: Doctors Nurses Dentists Midwives Prescribing Pharmacists

	Society of Homeopaths	*Including*: Homeopaths
	Treatments You Can Trust	*Including*: Doctors Nurses Dentists
	UK Council for Psychotherapy	*Including*: Counsellors Psychotherapists
	UK Public Health Register	*Including*: Public Health practitioners Public Health specialists Specialist registrars

Table 3: Occupations covered by neither regulators nor accredited registers

	Category	Roles
Currently unregulated occupations *N.B. This is intended to be indicative only and not a comprehensive list as the status of different occupations is subject to change*	Physical health	*Including*: Medical associates Health care assistants Nursing associates (in development) Complementary therapy practitioners not covered by relevant accredited registers
	Health science, promotion and protection	*Including*: Health records and patient information Clinical management Public health practitioners not covered by the relevant accredited register

	Mental health and wellbeing	*Including*: Psychological therapy practitioners and counsellors not covered by relevant accredited registers
	Social work and care (England only)	Including: Care workers/Care assistants Home care workers Personal Assistants

Table 4: Further membership bodies

	Voluntary registers not accredited by the Professional Standards Authority
N.B. This list is intended to be indicative only and not a comprehensive list as the status of different organisations and registers is subject to change	Action for Advocacy The Acupuncture-Acutherapy Council Alliance of Registered Homeopaths Association of Cardiothoracic Surgical Assistants Association for Cognitive Analytic Therapy Association for Nutrition Association of Osteomyologists Association of Physicians' Assistants (Anaesthesia) Association of Systematic Kinesiology Association of Traditional Chinese Medicine and Acupuncture UK British Academy of Western Medical Acupuncture British Association of Aesthetic Plastic Surgeons British Association for Behavioural & Cognitive Psychotherapies

	British Complementary Therapies Council
	British Psychological Society
	British Society of Clinical Hypnosis
	College of Sexual and Relationship Therapists
	Complementary Therapists Association
	Council for Anthroposophic Health and Social Care
	Counsellors and Psychotherapists in Primary Care
	Counselling and Psychotherapy Central Awarding Body
	Crystal and Healing International
	General Hypnotherapy Standards Council
	General Naturopathic Council
	General Regulatory Council for Complementary Therapies
	The Homeopathic Medical Association
	Independent Practitioners Network
	Institute for Complementary and Natural Medicine
	Institute of Biomedical Science
	The Institute of Chiropodists and Podiatrists
	Institute of Commissioning Professionals
	Institute of Healthcare Management
	Institute of Remote Healthcare
	National Council of Psychotherapists
	Physician Associate Managed Voluntary Register
	Public Voluntary Register of Sonographers

	Register of Exercise Professionals Registration Council for Clinical Physiologists Society for Vascular Technology of Great Britain and Ireland Society of Chiropodists and Podiatrists Society of Clinical Perfusion Scientists of Great Britain & Ireland Telopea Managed Services Ltd UK Association for Humanistic Psychology Practitioners UK Council for Health Informatics Professions Universities Psychotherapy and Counselling Association

Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road
London SW1W 9SP

Telephone: **020 7389 8030**
Fax: **020 7389 8040**
Email: **info@professionalstandards.org.uk**
Web: **www.professionalstandards.org.uk**

professional standards authority