

Report and Recommendations to the Secretary of State for Health on the conduct function of the General Social Care Council

September 2009

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1. Summary of review and findings

- 1.1 The General Social Care Council (GSCC) is a Non Departmental Public Body established in October 2001. It is responsible for setting standards of conduct and practice for social care workers and their employers, for regulating the workforce and for regulating social work education and training. It is an arms length body of the Department of Health (DH) and also works closely with the Department of Children Schools and Families.
- 1.2 Conduct is one of the four main statutory functions of the GSCC. The others are setting and promoting standards for the profession; maintaining a register of those who meet the standards and ensuring high standards of education for social workers. We have not looked at its other statutory functions or the overall governance of the organisation.
- 1.3 A new chair was appointed in November 2008 coinciding with staff changes at senior level and in early 2009 the GSCC identified a number of problems with the management and control of its conduct functions. Subsequently the GSCC identified that there was a significant number of unallocated cases within its conduct process which had not been risk assessed. The GSCC informed the DH and conducted an internal review. On 20 July 2009 the Secretary of State for Health announced in a written statement that he was commissioning the CHRE to carry out a review of the GSCC's conduct function. This report is our response to the Secretary of State's commission.
- 1.4 The new chair of the GSCC, its Council and managers are actively addressing the organisation's problems in the conduct functions. An interim chief executive was appointed in July 2009 and has taken immediate action with the Council to bring about improvements. A recovery plan has been developed and is under discussion with the Department of Health. We hope that this report and the recommendations in it will provide a check against that recovery plan and will be a constructive contribution to renewal and significant organisational change.
- 1.5 This review is concerned with the GSCC's conduct function, including its effectiveness, efficiency and governance. This review looks at events prior to July 2009 and primarily between April 2007 and April 2009.
- 1.6 During the course of this review we examined GSCC Council and committee papers, as well as other information supplied by the GSCC. We also audited 102 cases which had been considered by the GSCC under its conduct process in addition to a further 20 cases considered under an earlier audit. We interviewed members of staff and current and former Council members and received information from other parties. We received complete co-operation from everyone currently and formerly at the GSCC from whom we asked for information.
- 1.7 Many of the GSCC's conduct processes, and the way in which the conduct function was managed, did not help to promote public safety or the effective, efficient and timely consideration of cases.
- 1.8 The GSCC does not have a fully functioning case management system. This is a fundamental weakness and needs to be addressed as a priority. The absence of an effective case management system makes it virtually impossible for managers to manage the caseload efficiently as they do not have reliable information and statistics. This, in turn, makes it difficult for them to performance manage their staff. The lack of information on cases also means the Council and its committees could

not adequately hold members of the executive to account for the operational performance of the conduct function.

- 1.9 The conduct function lacked a robust performance management framework incorporating key performance indicators (KPIs) for the quality and efficiency with which cases were handled.
- 1.10 Decisions affecting the progress of cases have not always been taken on a public protection basis and at times cases have not been referred to the conduct committee or for an interim suspension order for financial reasons.
- 1.11 The work of the conduct team is undertaken from two locations, in London and Rugby. The position is further complicated by the fact that there are also a number of external investigators, who work on conduct cases predominately from home. The conduct function needs to be organised and managed as a single team with comprehensive quality standards to ensure consistent processes and outcomes in relation to cases.
- 1.12 We understand some staff were recruited who did not have experience of undertaking investigations, knowledge of regulation or experience in managing casework. The GSCC did not provide them with adequate initial training and guidance especially on making risk assessments on cases. This meant that they were not able to develop as required in the role.
- 1.13 The GSCC's conduct process needs amendments to its rules and legislation to bring it in line with the fitness to practise regimes operated by the best health professional regulators and envisaged in the White Paper, *Trust, Assurance and Safety*¹. Our audits suggested that concerns about the professional competence of social workers are rarely taken forward under the conduct process.
- 1.14 The GSCC also needs to be able to take a more active role in identifying and pursuing cases where there are concerns about social workers.
- 1.15 The conduct committee should have the power to impose conditions. Conditions are often the most effective sanction in terms of protecting the public and rehabilitating the registrant.
- 1.16 Appeals against decisions of the conduct committee were heard by the Care Standards Tribunal (CST) now known as the First-tier tribunal. This is another area in which the GSCC rules should be brought into line with the health professional regulators so that appeals are heard by the High Court.
- 1.17 We had concerns about many decisions made on cases. The GSCC was applying too high a threshold for the referral of cases to the conduct committee. This fails adequately to protect the public.
- 1.18 Risk assessment of conduct cases is a crucial area with significant public protection implications. However, where such assessments took place they were often made by an administrative assistant and not reviewed by managers. In many cases there is no documented evidence that an interim suspension order had been considered.
- 1.19 Good file management and record keeping is a crucial ingredient to effective case management. In nearly all the files we saw the quality of the record keeping was poor. Often it was not possible to tell who had made a decision, and sometimes it was not even possible to be sure what decision had been made.

¹ Department of Health (2007). *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. London: The Stationery Office

- 1.20 Where there had been contact with employers this had not been done in a sufficiently formal or rigorous manner. In a number of cases we gained the impression that employers were unwilling to provide detailed information.
- 1.21 We were not always convinced that the caseworkers considered all of the issues involved in the case. In many cases it was not possible to tell whether the reasons for closure were legitimate, because there was no record of them. The GSCC has closed cases without enough information to know what risk remains for the public. These practices, and the resultant lack of clear reasons for inaction, are likely to reduce the public's confidence in the ability of the GSCC to regulate the social workers.
- 1.22 There are three main concerns relating to the GSCC's Council's past governance of the conduct function. First, the lack of scrutiny of the conduct function. Secondly, the quality of information provided to the Council and its committees. Thirdly, the level of assessment of risk relating to the conduct function's work.
- 1.23 The multiple accountabilities of the GSCC do not seem to have helped to secure effective oversight. The sponsor division is the Professional Standards division, within the Workforce Directorate of the DH. In addition the Social Care Directorate of the DH has an important interest in the implementation of policy while the Department for Children Schools and Families has similar interests in relation to children and young people and the Arms Length Bodies Support Unit sets business planning frameworks.
- 1.24 The GSCC risk register did not adequately represent the main risks within the conduct function. The primary risk is failure to protect the public.
- 1.25 The existence of a backlog of cases was well known at all levels as can be seen by the repeated references in Council, Regulation Committee and EMT minutes. That no comprehensive plan of action was proposed, discussed or formalised indicates that the Council did not understand sufficiently the implications of failures within the conduct process.
- 1.26 The Council and its committees were often hampered in undertaking their oversight by the quality of information that they received. On occasion members were provided with misleading information, particularly in relation to how long the decision made in September 2007 not to refer cases to the conduct committee stayed in operation.
- 1.27 The lack of a clear statutory duty to protect the public has contributed to the GSCC failing to deliver an appropriate level of assurance around the standard of conduct and practice amongst social workers.
- 1.28 In order to have credibility with both the profession and the public a regulator must be seen to be independent of sectional interests. The GSCC's independence would be helped by it becoming more financially independent of government.
- 1.29 This model will require a more efficient GSCC and an increase in registration fees for social workers. We therefore consider that this new model of funding should be phased in over a number of years.
- 1.30 In achieving the primary goal of improving the standards and performance of social workers the GSCC would benefit considerably from being able to concentrate on the core activities of a modern regulator, the setting of standards, ensuring the quality of education, maintaining a register and ensuring fitness to practise.

2. Introduction

Background and governance of the GSCC

- 2.1 The General Social Care Council (GSCC) is a Non Departmental Public Body established in October 2001 under the Care Standards Act 2000. The GSCC is responsible for setting standards of conduct and practice for social care workers and their employers, for regulating the workforce, and for regulating social work education and training. It aims to raise and maintain high standards in social care. It is an arms length body (ALB) of the Department of Health (DH) and not fully independent of it as the health professional regulators are. It also works closely with the Department for Children, Schools and Families (DCSF).
- 2.2 The GSCC is governed by a Council whose members are independently appointed by the Appointments Commission on behalf of the Secretary of State for Health. Membership includes both public members and those with experience and expertise in social care. Observers from the DH and DCSF attend most of the Council meetings. Further oversight is provided by quarterly 'accountability meetings' attended by senior officials from the Departments and officers and senior staff of the GSCC. In addition the DH receives copies of the Audit Committee papers.
- 2.3 The GSCC internal audit is provided by AHL Ltd and external audit by the National Audit Office.
- 2.4 During the period which is the subject of this review an executive management team (EMT) consisting of the chief executive, director of regulation, director of corporate resources and director of strategy was in place².
- 2.5 The chief executive is the Accounting Officer for the GSCC. He was responsible for 'leadership on risk management' by chairing the EMT 'at which all major strategic management, implementation and resource decisions' were taken³. The EMT had 'responsibility for the financial performance and risk management of the organisation'⁴.
- 2.6 In 2007-08 the GSCC had an average of 230 whole time staff of whom 53 were agency staff. It had operating costs of £42 million of which £26.5 million was education support grants. The cost of the conduct function was £640 thousand with an additional £1.35 million in legal costs.
- 2.7 Coordination and cooperation between social care and health professionals has become increasingly recognised as good practice. Such coordination is particularly important where the protection of children or vulnerable adults is concerned. A proper level of independent regulation across both social care and health is essential if the professionalism of social workers and the children's workforce is to be properly supported and challenged to deliver the highest possible practice standards.

The conduct function

- 2.8 The conduct function employs approximately 50 staff in Rugby and London and a pool of external investigators and is accountable through the Director of Regulation to the EMT.

² In this report we use 'executive' to refer to one or more members of the Executive Management Team

³ GSCC Annual Report and Accounts 2007-08, Page 43. London – The Stationery Office

⁴ GSCC Annual Report and Accounts 2007-08, Page 47. London – The Stationery Office

- 2.9 Conduct is one of the four main statutory functions of the GSCC. The others are setting and promoting standards for the profession; maintaining a register of those who meet the standards and ensuring high standards of education for social workers.
- 2.10 The conduct process is the means through which the GSCC can take action to protect the public when a social worker is alleged to have committed misconduct. In the most serious case this can include referral for a hearing by the conduct committee which can remove the social worker's name from the register, preventing them from practising as a registered social worker in the UK. When there is judged to be immediate risk to the public the GSCC also has the power to impose an interim suspension order (ISO) covering the period up to when the case against the social worker is considered by the conduct committee.
- 2.11 An effective conduct function is crucial in protecting service users and other members of the public. Ensuring that fair, proportionate and timely action is taken where a social worker has committed misconduct is essential for the following reasons:
- to ensure that service users are protected from social workers who present a risk of direct harm to them
 - to maintain confidence in the profession
 - to maintain confidence in the system of regulation
 - to ensure that social workers are treated fairly
 - to ensure that social workers have confidence in their regulatory body.

The concerns about the conduct function

- 2.12 In early 2009 the GSCC identified a number of problems with the management and control of its conduct function.
- 2.13 The GSCC invited us to carry out a full performance review of the organisation, using the process we have developed to assess the performance of the health professional regulators. CHRE does not have statutory oversight of the GSCC and because we were undertaking our performance review of the health professional regulators we did not have the resources to do this at the time. However, we did carry out an audit of a small number of decisions made under its conduct process. This audit identified a number of concerns which were reinforced by this review and are detailed elsewhere in this document. A report was submitted to the GSCC in June 2009.
- 2.14 Shortly after we undertook that audit the GSCC identified that there was a significant backlog of unallocated cases within its conduct process and that some of these cases had not been risk assessed. The GSCC informed the DH and conducted an internal review. On 20 July 2009 the Secretary of State for Health announced in a written statement that he was commissioning the CHRE to carry out a review of the GSCC's conduct function (see Annex 1). CHRE was asked to report by the end of September 2009.
- 2.15 We understand that there has been a backlog of cases in conduct for many years and, although no reliable statistics are available, at times there was a reported backlog in excess of 700 delayed cases within the system⁵. However, the existence of the large number of unallocated cases reported to the DH in July 2009 was even more concerning as it included cases on which there had been no risk assessment. This had significant public protection implications.

⁵ Report to Regulation Committee meeting on 22 February 2007

2.16 We are aware that since the GSCC identified these problems it has prioritised action to address them, developed a recovery plan and concentrated its work in conduct on its aim of protecting the public.

3. The scope and conduct of our review

Terms of Reference and scope of the review

- 3.1 The Terms of Reference for our review are set out in Annex 2.
- 3.2 This review is concerned with the GSCC's conduct function, including its effectiveness, efficiency and governance.
- 3.3 Our main findings are set out under four areas, and are contained in sections 4 to 7 of this report:
- The conduct processes and management of the conduct function
 - The quality of decisions made on conduct cases
 - Oversight and governance of the conduct function
 - Purpose and powers of the GSCC
- 3.4 Within each section where we have identified issues we have also made recommendations. We have drawn upon our knowledge of how the health professional regulators deal with similar functions. Our recommendations focus on the outcomes of good regulation and are aimed at supporting the GSCC in improving its performance and prioritising public protection.

Powers, resources and sources of evidence

- 3.5 The Council for Healthcare Regulatory Excellence is an independent body accountable to Parliament. Our primary purpose is to promote the health, safety and well-being of patients and other members of the public. We scrutinise and oversee the health professional regulators, working with them in identifying and promoting good practice in regulation, carrying out research, developing policy and giving advice.
- 3.6 CHRE does not have statutory oversight of the GSCC as it does with the nine health professional regulators⁶. We conducted this review at the invitation of the GSCC as commissioned by the Secretary of State for Health.
- 3.7 This review was conducted by CHRE's Scrutiny and Quality team augmented by two independent auditors.
- 3.8 During the course of this review we examined GSCC Council and committee papers, including papers from the Regulation and Audit Committees, minutes of accountability meetings with the Department of Health, as well as other information supplied by the GSCC. We also audited a further 102 cases which had been considered by the GSCC under its conduct process, in addition to the 20 cases in our original audit referred to in paragraph 2.13 above. Information on how we selected our samples is at Annex 3.
- 3.9 We interviewed members of staff and current and former Council members. These interviews were confidential to enable a full and frank discussion to take place. A list of the Council members with whom we spoke is at Annex 4.

⁶ General Chiropractic Council (GCC); General Dental Council (GDC); General Medical Council (GMC); General Optical Council (GOC); General Osteopathic Council (GOsC); Health Professions Council (HPC); Nursing and Midwifery Council (NMC); Pharmaceutical Society of Northern Ireland (PSNI) and Royal Pharmaceutical Society of Great Britain (RPSGB)

- 3.10 We received correspondence from interested parties, including from people who have submitted complaints to the conduct team. We also spoke with the Director General for Social Care and the Head of Standards and Regulation at the Department of Health.
- 3.11 We wrote to professional associations and unions with a remit in social care to invite evidence (see Annex 5). None of them provided evidence to this review.
- 3.12 We received complete cooperation from everyone at the GSCC during the course of this review. The suspended chief executive had sight of this report in draft and we met with him to discuss it. We found his comments helpful and appreciated his cooperation. We are very grateful to the GSCC for the efforts to which they went to supply us with the requested evidence. Everyone was open and helpful and provided all of the information we requested. Everyone we asked to speak with agreed. The content of this report is however the responsibility of CHRE alone.

4. The conduct processes and management of the conduct function

- 4.1 Many of the GSCC's conduct processes, and the way in which the conduct function has been managed, did not deliver public safety or the effective, efficient and timely consideration of cases and therefore undermined the GSCC's goal of promoting public safety.
- 4.2 In this section we discuss a range of matters, including the absence of an effective case management system and systems for allocation of cases; performance management; the management of the conduct function by the executive; the division of the work across more than one site; the skills and experience of the staff and the quality of guidance and training they receive; the need for a comprehensive fitness to practise process and the powers of the conduct committee and the role and training of its members.

The absence of an effective case management system and systems for allocation of cases

- 4.3 The GSCC does not have a reliable and fully functioning case management system. This is a fundamental weakness and needs to be addressed as a priority.
- 4.4 The absence of a comprehensive case management system causes many serious problems. It makes it virtually impossible to manage the caseload effectively, as they do not have reliable information and statistics. This, in turn, makes it difficult for managers to performance manage their staff effectively. The lack of information on cases also means the Council and its committees could not adequately hold members of the executive to account for the operational performance of the conduct function.
- 4.5 Until August 2009, cases were recorded by the different sections within the conduct team using separate spreadsheets. There was no single facility in place to:
- log cases and record all relevant details
 - identify high-risk cases
 - record key deadlines and progress against target timescales
 - identify who was responsible for each case or whether the case had been allocated
 - provide accurate, reliable and up to date management information.
- 4.6 Over a number of years the GSCC has been developing a case management system covering the registration and conduct functions. This is called the Online Social Care Register (OSCAR). The use of OSCAR by the different sections of the conduct team was inconsistent. Any corporate direction from the executive as to what was required on the use of the system was not complied with. Investigators were allowed to dispense with its use in part or completely. There is no record of the EMT formally sanctioning this position but the staff we spoke with claimed that the position was tacitly accepted by the EMT.
- 4.7 It was intended that OSCAR would ultimately be used to support both the registration and conduct functions but it was initially developed for use by the registrations team. We have heard conflicting reports as to its potential utility as a case management system for the conduct function. It was reported to the

Regulation Committee in February 2008⁷ that an update (Release 3) would create such a case management system for conduct.

- 4.8 There has not been any systematic tracking and monitoring of cases. We understand that historically cases were allocated to investigation officers almost on an *ad hoc* basis and managers have not consistently undertaken any oversight of their caseloads. The number of unallocated cases grew partly because there was no complete understanding of the caseload and a decision was made not to allocate any cases to investigation officers as it was believed that they were too busy with their existing caseloads.
- 4.9 During the period of our review the GSCC developed an EXCEL database. This is a sensible interim measure but a fully planned, fit for purpose system is needed.
- 4.10 **We recommend** that an effective case management system to support the conduct function should be implemented as a matter of urgency. This must then be supported by oversight by managers who must be responsible for the allocation of cases and ongoing management of the caseload to ensure that appropriate and timely action, including risk assessment, is taken at each stage.
- 4.11 In developing the case management system the GSCC might find it useful to liaise with other regulatory bodies with similar functions.

Performance management

- 4.12 The conduct function lacked a robust performance management framework incorporating key performance indicators (KPIs) for the quality and efficiency with which cases were handled.
- 4.13 The KPI's that were monitored and agreed by EMT and Council as part of the annual Business Planning process were inadequate. They did not allow measurement of the entire conduct process and did not measure those areas that would be expected to be critical in an assessment of regulatory performance. This is clearly indicated by the fact that the 2008/09⁸ performance indicated that all targets had been achieved. The figures did not reflect the increasing backlog of unallocated cases, the lengthening of the time taken to complete investigations or the extent of the problem with the unidentified mislaid files.
- 4.14 Given the lack of a case management system and any effective mechanism to monitor case work in a single consistent manner, it is difficult to understand how the reported performance figures for 2008/09 were calculated. For example, we have been unable to identify how the GSCC would have had information to be able to report on its KPIs 'To investigate and dispose of 90% of all referrals within 4 weeks of receiving appropriate information' (KPI 3.1) and 'To complete 80% of Formal Complaints, from the day the case is referred to conclusion, within 78 weeks' (KPI 3.2).
- 4.15 The KPIs also failed to take account of all complaints as cases were only recorded as a formal complaint once the required level of 'pre-investigation' had been carried out and the Management Screening Panel had adjudged it to be a complaint.
- 4.16 KPI 4.1 requires '90% of Conduct Cases to achieve desired outcome'. Actual measurement is taken against only those conduct cases which progress to a

⁷ GSCC Regulation Committee Meeting – 20th February 2008. Item 3, reference RC/2008/18

⁸ GSCC Council Meeting – 18th May 2009. Chief Executive's Report, Annex C – Summary of Performance 2008-09

hearing and, therefore, represent only a small part of activity undertaken within the team. A target focused solely on the achievement of a certain outcome creates an incentive not to pass a borderline case to the committee as a non-finding of misconduct would result in the target being missed. This is not conducive to robust public protection. Furthermore, this target does seem rather inappropriate as the GSCC could ensure that it was met by only referring the most serious cases.

- 4.17 **We recommend** that KPIs should be developed to measure clear regulatory outcomes. In the short term, the KPIs should reflect the improvements required to the conduct function and will, therefore, enable the GSCC to report on progress against a valid and effective improvement plan. In the longer term, the KPI's should focus on the progress of cases and the demonstration of public protection.

The management of the conduct function by the executive

- 4.18 The Director of Regulation represents the conduct function on the EMT and is also responsible for other areas of the GSCC's functions, including registration and education.
- 4.19 All the staff we spoke with in the conduct team were consistent in informing us that they felt pressurised by the executive in 2007-8 into not proceeding with conduct cases, regardless of the public protection implications because of budget restrictions. We find their evidence compelling.
- 4.20 A decision was taken by EMT on 4th September 2007⁹ 'to advise the Conduct Manager not to make any formal commitment to schedule any more conduct hearings until the next financial year'. This decision was communicated to all managers across the GSCC via an email on 6th September 2007.
- 4.21 The Chief Executive's Report to the Council on 24th September 2007¹⁰ confirms this decision where it states, 'The Head of Conduct was asked not to make any formal commitment to schedule any more conduct hearings until the next financial year'. The minutes for the Council Meeting at which the report was presented do not document acknowledgement, acceptance or challenge of this decision. Our discussions with Council members suggest that they believed that the DH had approved this decision.
- 4.22 At the subsequent Council meeting on 26th November 2007¹¹, it was reported through the Chief Executive's Report that the GSCC 'were able in early October to begin the process of scheduling hearings again following a review of the [financial] position and an update was provided to the Regulation Committee. The Chair of the Council has communicated directly with our independent committee members about the situation'. The minutes for the Council meeting¹² document this decision thus, 'The Chief Executive reported that DH had agreed to this virement and that he was confident now that the GSCC would be able to schedule all the necessary hearings required in this financial year if the expected changes in the Rules are in place'.
- 4.23 There is, however, no evidence that an update on this position was provided to the Regulation Committee. The minutes for the Regulation Committee of 11th October 2007¹³ state, 'The Director of Regulation informed members that, as a result of the projected overspend in the Conduct budget reported to Council on 24 September, it

⁹ Executive Management Business Meeting – 4th September 2007. Paragraph 5.1

¹⁰ GSCC Council Meeting – 24th September 2007. Chief Executive's Report, Section 4, Paragraph 101

¹¹ GSCC Council Meeting – 26th November 2007. Chief Executives Report, Section 1, Paragraph 14.

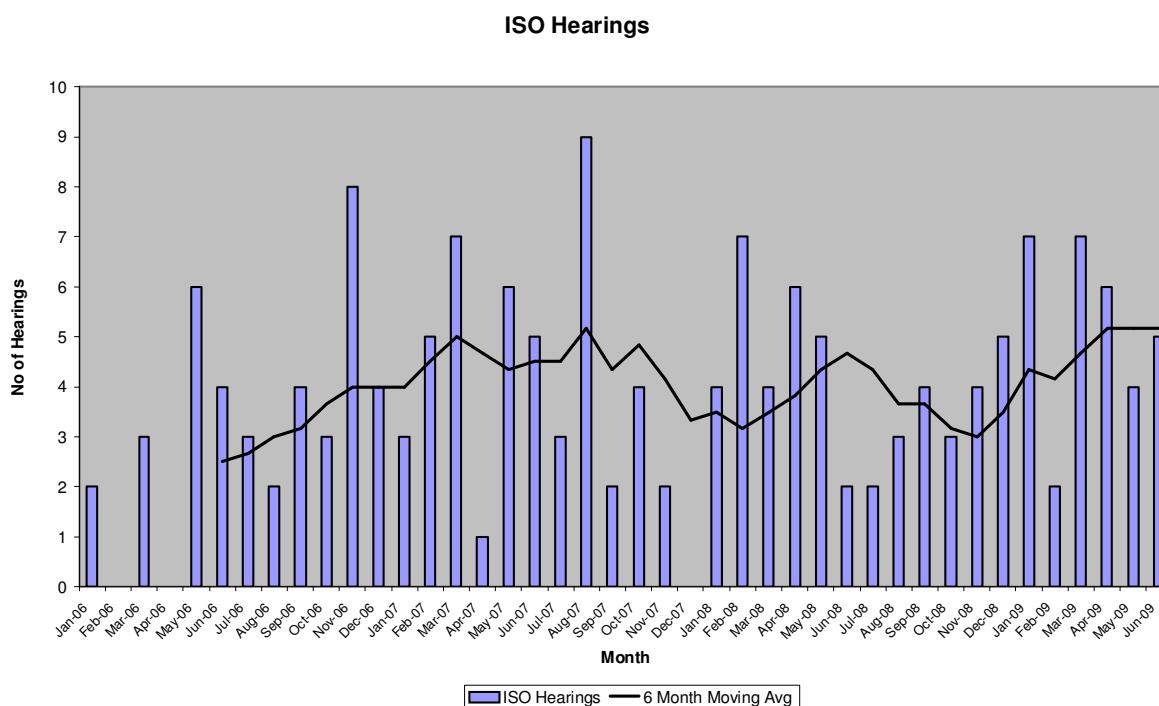
¹² GSCC Council Meeting – 26th November 2007 – Ref: GSCC/2007/240

¹³ Regulation Committee Meeting – 11th October 2007. Item 3, Ref RC/2007/47

had been decided for the time being not to schedule further conduct hearings which have not been formally notified. This decision was pending a further review of the financial situation and agreement by the DH to the proposed changes to the registration and conduct rules, which will in themselves save financial resource. The committee accepted that the present situation was the result of conduct activity exceeding the GSCC's expectations. The Director of Regulation reassured members that officers were keeping the situation under constant review and that the learning from this will enable a better understanding of future conduct activity and cost projections'. No further reference was made to this decision or the change in strategy as reported to the Council at either this or subsequent Regulation Committee meetings.

- 4.24 Despite this, we understand that the executive instructed the staff to continue to comply with the original instruction of September 2007. An email in July 2008 confirming that this instruction had been put into operation stated, 'In response to last year's budget pressures and delayed new rules conduct deferred all conduct cases in December 07 January 08 and February in all cases unless they were agreed as ISO applications by the Head [of Conduct] or Director [of Regulation]. No expectations (*sic* – we understand this is meant to be exceptions) were made and the records show this to be the case. This is to clear up any more misconceptions that we did not take this action'.
- 4.25 Our interviews with key staff and the above email supported the view that the executive had made it clear at the time indicated above that cases were to be delayed until the next financial year (April 2008 – March 2009) as there were severely limited funds.
- 4.26 In the following year spending within conduct and committee services was strictly limited to the budgets allocated, with no flexibility to be provided in the event of an increase in workload outside the expectations when budgets were set. The inevitable impact of this was that staff within conduct delayed cases until additional funding became available.
- 4.27 Staff within the conduct team were also under the impression that they should not refer cases for a hearing for an interim suspension order (ISO) unless they were extremely serious, such as cases involving violence or child abuse. Consequently the thresholds applied by the staff did not return to the level that was in place prior to these financially driven decisions being taken. This perception was supported by a number of key staff within the conduct team interviewed as part of this review.
- 4.28 We were able to identify trends that would support the assertion that the threshold for an application for an ISO had been raised during the period towards the end of 2007. Figure 1 shows the number of ISO hearings held each month from January 2006 to June 2009. A six month average line has been overlaid and this demonstrates that there was a marked drop in the number of ISO hearings in September 07 which continued until March 08. There is no equivalent fall in the number of enquiries, referrals or complaints received in the same period.
- 4.29 A similar drop in the period July 2008 to November 2008 supports the impression that there was a restriction on scheduling hearings in this period as well.

Figure 1



4.30 The issue of financial resources has been raised with us many times during this review. We are not in a position to judge whether the GSCC was given adequate resource to deliver all its statutory responsibilities successfully or, whether it used those resources efficiently. We recognise that public funding must be based on value for money but also that decisions about risk in relation to public protection should not be led by financial restraint. We note that during the period covered by this review the GSCC was making savings in its costs as a result on an overall cut in its funding.

4.31 **We recommend** that all decisions affecting the progress of cases should be taken on a public protection basis.

Division of the work across more than one site

4.32 The work of the conduct team is undertaken from two locations, in London and Rugby. This is the result of the DH ALB Review¹⁴ decision that ALBs, including the GSCC, should re-locate all or part of their functions from London and South East. The position is further complicated by the fact that there are also a number of external investigators who work on conduct cases predominately from home.

4.33 The conduct function needs to be organised and managed as a single team to ensure consistent high quality outcomes in relation to cases. An effective case management system must be in place if the work is to continue to be carried out from multiple locations.

¹⁴, *Reconfiguring the Department of Health's Arms Length Bodies* Department of Health 2004

- 4.34 The teams based in London and Rugby, along with the external investigators, undertook essentially the same activities within the conduct function. However, there appears to be little coordination and synchronicity between the three teams in terms of process application, use of software and spreadsheets and knowledge sharing.
- 4.35 There were no formal combined team meetings involving staff from all three teams and there appears to have been no mechanism for knowledge sharing between teams. This did not encourage consistent decision making. We were unable to satisfy ourselves that the same outcome would have been achieved in a similar timeframe if the same case was completed by a team member in Rugby compared to one in London. The allocation process (the process by which cases are allocated to either the London, Rugby or External Investigators teams) was *ad hoc*. Cases were not allocated on a specialism or knowledge basis and appear to take little account of individual investigator capacity.
- 4.36 **We recommend** that the two geographically distinct teams and the external investigators should be managed and operated as a single team. Managers need to take a coherent approach with consistent oversight of the function. All processes, deadlines, performance management, allocations and record keeping should be consistent. There should be more regular, formal and structured engagement within the conduct team at the different locations.

The skills and experience of the staff and the quality of guidance and training they receive

- 4.37 We understand some staff were recruited in Rugby who did not have experience of undertaking investigations, knowledge of regulation or experience in managing casework. The GSCC did not provide them with adequate initial training and guidance. This meant that they were not able to develop as required in the role. The performance management of these staff was also ineffective.
- 4.38 There is now a comprehensive *Investigation Manual* in place which provides guidance to staff, but this was not in place at the time the majority of the new staff were recruited in Rugby. We understand that, most importantly, the new staff recruited in Rugby did not receive training or guidance on making risk assessments on cases.
- 4.39 **We recommend** that a conduct team skills audit and development plan should be produced. This should review all staff members' current competencies and identify the competencies required for each role. Where there are discrepancies, training needs should be identified and appropriate training should be provided.

Need for a full fitness to practise process

- 4.40 The GSCC's conduct process needs amendments to its rules and legislation to bring it in line with the fitness to practise regimes operated by the best health professional regulators and envisaged in the White Paper, *Trust, Assurance and Safety*¹⁵. Our audits suggested that complaints about the competence of social workers are rarely taken forward under the conduct process as the GSCC has no procedures to allow it to assess the professional performance of social workers about whom there have been concerns expressed.

¹⁵ Department of Health (2007). *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. London: The Stationery Office

- 4.41 The GSCC does not have specific statutory powers to deal with allegations relating to the professional competence of social workers. It took the view from the outset that responsibility for addressing issues of professional competence should rest with employers and that the GSCC's role should be restricted to dealing with misconduct issues. In relation to this, however, it adopted a policy, which appears not to have been fully understood by some staff, that a conduct case could be taken forward in circumstances where a social worker was knowingly practising beyond their competence. The executive told us that the GSCC could take competence cases in these circumstances but some staff in the conduct team did not seem to understand this policy or to put it into practice.
- 4.42 Under the present rules and processes the focus is on whether a social worker has committed misconduct. This means that concerns relating to lack of competence tend not to be assessed. The GSCC should seek to replace the test of misconduct with one of whether the social worker's fitness to practise is impaired, again bringing it into line with the majority of the health professional regulators.
- 4.43 The GSCC also needs to be able to take a more active role in identifying and pursuing cases where there are concerns about social workers. We were concerned to learn, both from evidence from our case audits and accounts from staff at the GSCC, that employers often do not readily supply information to the GSCC, even in some cases where there are very real public protection issues at stake. We understand that employers are required to inform the GSCC if they dismiss a social worker. However, it would appear that some employers only supply the minimum information required to meet their legal obligations and do not co-operate with the GSCC's investigations. The GSCC needs to pursue such cases more seriously than it has on occasions in the past and additional powers will be necessary if employers continue not to co-operate. The GSCC has been seeking these powers for some time.
- 4.44 **We recommend** that the GSCC and DH should review the current primary and secondary legislation relating to the conduct process and replace it with a fitness to practise process which allows it to assess both competence and conduct.

The powers of the conduct committee and the role and training of its members

- 4.45 Although in our audits we found that most decisions made by the conduct committee were reasonable and well explained, there are some weaknesses with the committee which need to be addressed.
- 4.46 The most important of these is that the GSCC's conduct committee has, and always has had, a relatively limited range of sanctions available to it. The options available to the conduct committee on any cases are:
- to take no action
 - to admonish the social worker and direct that a record of the admonishment be placed on the register for a period of up to five years
 - to suspend the social worker for a period of up to two years
 - to remove the social worker from the register.
- 4.47 The conduct committee should have the power to impose conditions. Conditions are often the most effective sanction in terms of protecting the public and rehabilitating the registrant. Conditions are generally only effective if the regulator has the co-operation of employers, who usually have a crucial role in monitoring compliance.

This is another reason why the GSCC must try to strengthen its relationship with employers in respect of conduct. The GSCC has been seeking these powers for some time.

- 4.48 Appeals against decisions of the conduct committee are heard by the Care Standards Tribunal (CST). Concerns have been expressed that the CST apply a lower threshold in overturning decisions than the High Court, which hears appeals in relation to the health professional regulators' cases. This is another area in which the GSCC rules should be brought into line with the health professional regulators so that appeals are heard by the High Court.
- 4.49 **We recommend** that the conduct committee should be given the power to use all of the sanctions now available to the fitness to practise committees/panels of the majority of the health professional regulators. The DH should consider this in the context of CHRE's work on harmonising sanctions across health professional regulation¹⁶.
- 4.50 **We recommend** that the relevant legislation should be amended so that appeals against decisions made by the conduct committee are heard by the High Court rather than the Care Standards Tribunal.

¹⁶ Council for Healthcare Regulatory Excellence, 2008. *Harmonising Sanctions, CHRE's position*. London, CHRE

5. The quality of decision making on conduct cases

- 5.1 Our findings on the quality of decisions made on conduct cases are based on the two audits which we have undertaken (see paragraph 3.8). When undertaking these audits we assessed the GSCC's decisions using our experience of scrutinising fitness to practise decisions of the health professional regulators.
- 5.2 We had concerns about many decisions made on cases and have specifically drawn the attention of the GSCC to four cases for them to reconsider as we felt that there was a risk of harm to the public. Our main areas of concern are summarised below.

Cases only being referred to a conduct committee hearing if it is felt that the outcome will be removal

- 5.3 The GSCC was applying too high a threshold for the referral of cases to the conduct committee. We identified cases which were closed at the initial stages which should have been referred on for an investigation with a view to a conduct committee hearing. These cases included criminal convictions.
- 5.4 Senior staff and Council members of the GSCC to whom we spoke told us that they all understood that the Department of Health was aware of and concurred with the policy that only cases of the greatest seriousness should be taken forward.
- 5.5 We regularly see outcomes of cases involving allegations which have been considered by final fitness to practise panels from the health professional regulators. These cases would not necessarily result in the social worker being removed from the Register. Normally if the allegation is found proved there would be some sanction imposed on their registration.
- 5.6 It would appear from our audit, and our discussions with staff and Council members, that cases were referred only if it was felt that removal of the social worker's name from the register would be the likely outcome. This means that some cases not at the very highest level of seriousness but which would be likely to result in some sanction are not referred with a consequent risk to the public.
- 5.7 This is demonstrated by the fact that most of the cases considered by the conduct committee related to very serious allegations. Of the 30 cases determined by the conduct committee between April 2008 and March 2009, 18 resulted in removal, four in suspension, seven in admonishment and one a finding that the social worker was not guilty of misconduct. The percentage of cases resulting in removal from the register by the GSCC's conduct committee, which is 61 per cent, is considerably higher than the corresponding percentage relating to cases heard by all the health professional regulators' fitness to practise panels, which is approximately 30 per cent for the same period.
- 5.8 **We recommend** that the GSCC should adopt a lower threshold of referral of cases to the conduct committee. Cases should be referred if there is a realistic prospect of a sanction being imposed. This must be incorporated into the relevant guidance for staff. The availability of conditions as a sanction would greatly aid a proportionate approach to fitness to practise.

Risk assessments

- 5.9 Risk assessment is a crucial area with significant public protection implications.
- 5.10 All new cases need to be risk assessed as a matter of priority and a decision made on whether they need to be referred for an interim suspension order. They should also be risk assessed when any new information is received on the case. These risk assessments should always be signed off by someone who has sufficient experience to make these important judgements. It appears from our discussions with staff and from the audit that where such risk assessments took place they were often made by an administrative assistant and not reviewed by managers.
- 5.11 In many cases there was no documented evidence that an ISO had been considered. In some cases where an ISO had been sought there were instances of delays of several months before this happened.
- 5.12 **We recommend** that with immediate effect all new cases are risk assessed, including being signed off promptly by a person with sufficient competence and authority. Ongoing risk assessments should be completed within similar timescales. The risk assessment should include consideration of whether there is a need for an ISO.

Delays

- 5.13 Many cases at the pre-investigation and investigation stages (including some currently open) had considerable delays. Examples include:
- several cases with long unexplained periods of inactivity
 - one case where actions only happened each time the complainant complained about delays
 - one case open nearly three years before being closed despite not being a complex case
 - failure to chase requested information, including one case in which it took six months to write to the complainant asking for information
 - poor liaison with employers leading to the wrong person being asked to provide information.

Poor record keeping and file maintenance

- 5.14 Good file management and record keeping is crucial to effective case management. In nearly all the files we reviewed the quality of the record keeping was poor. Usually there is no audit trail to show who made a decision and for what reason. Where decisions are recorded they are often not signed off on the file. Most files contained examples of unsigned minutes, memos, notes of telephone conversations and letters. Often it was not possible to tell who had made a decision, or even sometimes to be sure what decision had been made on a case.
- 5.15 This issue should be addressed urgently, as it impacts on the quality of decision making. Also, the GSCC could be at risk if any of their decisions were challenged, such as by means of judicial review, as the Courts would be critical of the quality of records.

- 5.16 **We recommend** that comprehensive guidance on good file management should be given to all staff, and that managers should ensure that it is complied with routinely and that all files are capable of being audited.

Over-reliance on local investigations and lack of co-operation from employers

- 5.17 We were concerned that in a number of cases containing serious allegations, a decision was taken to close the case on the basis of very limited information supplied by employers. In these cases, there appeared to be little or no attempt to obtain further information or clarification of the extent and quality of the local investigation whether by employers or by the police. We were not confident from the information on the files that the local investigations had been sufficiently thorough and we find it hard to believe that the GSCC could have been assured from the information they had that there was no public protection risk.
- 5.18 Generally, where there had been contact with employers this had not been done in a sufficiently formal or rigorous manner. Sometimes the contact with the employer appeared to have been conducted entirely by telephone but the records on file of the conversations were not detailed. In view of the importance of this information we consider that there should always be a clear written record and the GSCC should obtain a written statement from the employer of the position.
- 5.19 We were particularly concerned that in one case the GSCC took the word of the social worker themselves that the local investigation had concluded that there were no public protection concerns. In this case there was no evidence that the GSCC verified the position with the employer.
- 5.20 In a number of cases we gained the impression that employers were unwilling to provide detailed information. This is a matter of concern and should be tackled with employers on a national level and, if necessary, the GSCC should seek statutory powers to require a greater level of co-operation from employers.
- 5.21 We feel strongly that increased liaison with employers is crucial, to encourage a greater level for referral and disclosure on specific cases. However, we feel this liaison with employers is also important in relation to ongoing consideration of specific cases. There were some cases which were closed on the basis that the employers were aware of the problem and had monitoring procedures in place. On the face of it, this seemed a sensible approach. However, it was far from clear whether the employers would contact the GSCC if the position changed or if the social worker left their employment.
- 5.22 **We recommend** that the GSCC should attempt to strengthen its relationships with employers in relation to conduct issues, with the aim of increasing the level of co-operation and information sharing. The Government should provide the GSCC with additional powers to require employers and others to provide information or concerns about a social worker's fitness to practise to the GSCC.
- 5.23 In the longer term, when good working relationships with employers are established, the GSCC might wish to consider whether they could adopt some of the procedures used by some other regulators. These procedures enable lower level concerns to be managed at the local level, but on the understanding that they will be referred back to the regulator if the position changes.

Failure to consider all relevant issues appropriately and to give proper reasons for closure

- 5.24 The conduct staff have not always considered all the relevant issues involved in the case. For example, in a case involving a social worker subject to a criminal conviction consideration was confined to the allegation that the social worker lied to the police about her profession. Little or no consideration appeared to have been given to the circumstances of the conviction.
- 5.25 In many cases it was not possible to tell whether the reasons for closure were legitimate, because there was no record of them beyond the following:
- The typical statement to complainants that the allegation was 'not a complaint'¹⁷. This term was used often when the matter clearly was, by any normal understanding, a complaint about a social worker. The GSCC regularly also made decisions contrary to its own internal definitions of a complaint¹⁸.
 - Insisting that the matter must first go through local employer complaint procedures before the GSCC can act. This is despite the fact that the GSCC is not a resolver of disputes and lack of completion of a complaints procedure does not prevent them from making an assessment of whether the social worker has committed misconduct. A local investigation may be a source of useful information but it is not an alternative to the regulator fulfilling its public protection duty. We could see no reference to the claimed 'local procedure requirement' in the GSCC rules or policies.
 - A decision had been taken either to remove a social worker's name from the register because they had not renewed their registration, or to allow voluntary removal. Some of these decisions took place many months after the receipt of a complaint, but removal was granted as the GSCC had not yet deemed the matter a 'complaint'. This was despite the fact that the social worker remained on the register right up to the point the GSCC decided to remove them apparently so that they could close the case. This gives the appearance that the GSCC was looking for reasons not to investigate matters. If the social workers reapply in due course it would be difficult to re-open investigations and the social worker may put forward an argument of abuse of process.
- 5.26 We reviewed other cases involving potentially very serious matters and found the GSCC had closed cases without enough information.
- 5.27 **We recommend** that the GSCC should give clear reasons when they close a case explaining why the social worker should not be referred to the conduct committee on the basis that they do not present a risk to the public. The GSCC should also clarify, and strictly apply, its policies on how to handle social workers who have not renewed their registrations and those who apply for voluntary removal whilst under the conduct process.

¹⁷ This meant 'not a complaint according to the GSCC's conduct rules'.

¹⁸ The GSCC (Conduct) Rules 2008 Section 12(2) '...a) relates to an identifiable Registrant; and (b) makes a specific allegation or allegations of misconduct against the Registrant;']

6. Oversight and governance of the conduct function

- 6.1 There are three main concerns relating to the GSCC Council's governance of the conduct function. First, the lack of scrutiny of the conduct function both by the Regulation Committee in particular and the Council as a whole. Secondly, the quality of information provided by the executive to the Council and its committees. Thirdly, the level of assessment of risk relating to the conduct function's work.
- 6.2 This report highlights the importance of the balance of responsibilities between the Council, the audit committee, the Accounting Officer and EMT and external scrutiny by the Department of Health and National Audit Office. Reliable and comprehensive management information is essential for all these to fulfil their roles. The Council must be properly enquiring but they have a reasonable expectation of being able to trust the information they are given by the executive. As indicated in 2.5 above formal responsibility for risk management in public bodies falls to the Accounting Officer.

Scrutiny of the conduct function by the Council and its Committees

- 6.3 There is evidence that the level of scrutiny and oversight undertaken by the Council and Regulation and Audit Committees over the operation of the conduct function was not sufficiently challenging.
- 6.4 Reliance was placed on information provided with limited evidence of challenge of statistics or further investigation into what some of the figures actually meant. As an example, a backlog of conduct cases was regularly reported through various mechanisms, but there is little evidence of a challenge as to what the backlog consisted of, whether it was increasing or decreasing, the age profile of the backlog and what action management were taking to address the backlog. Minutes record that the Council was constantly being reassured that changes were imminent that would result in an improvement in the conduct function's work but subsequent information on these areas was not provided to the Council or Committee. We note that no formal action log was in place within either the Council or the Regulation Committee that would have allowed the progress of specified actions to be monitored.
- 6.5 Perhaps as a consequence of the way in which the GSCC was originally set up, there appears to have been an emphasis on the registration process. While this focus on registration was understandable in the early stages of the GSCC's existence, once the Register was established, and conduct cases appeared, there was a requirement to ensure the conduct function was operating effectively.
- 6.6 **We recommend** that Council and Committee members should provide effective scrutiny by challenging information provided and requiring senior management to demonstrate what they have done to address identified issues.

Risk Management

- 6.7 The GSCC risk register did not adequately represent the main risks within the conduct function. The primary risk is the failure to protect the public. It was not until the extent of the unallocated cases had been identified and understood that conduct was identified as an area of significant risk. We were informed in interviews with a range of key staff that the the possibility of cases not being dealt with properly with

consequent risk to the public was not seen as a risk that needed managing unless or until such a case happened.

- 6.8 The existence of a backlog of cases was well known at all levels as can be seen by the repeated references in Council, Regulation Committee and EMT minutes. That no comprehensive plan of action was proposed, discussed or formalised indicates that the Council did not understand sufficiently the implications of failures within the conduct process.
- 6.9 **We recommend** that the GSCC review their approach to risk management to ensure that it is effective in identifying, recording and managing risks within the organisation. Where required, training should be provided. This should include Council members, senior management and all operational staff.
- 6.10 Neither the GSCC's internal auditors, AHL Limited, nor the external auditors, the National Audit Office (NAO) with their outsourced provider KPMG LLP, expressed recorded concerns about the GSCC's management of risk in the conduct function.
- 6.11 The *Annual Report and Accounts 2007/08*¹⁹ were signed off by the NAO with 'no observations to make'. Following the June 2008 Audit committee meeting, internal audit and external audit met with committee members separately (without officers present) and 'there were no matters of concern raised that required any form of report to the Council'²⁰. We recognise that the responsibilities of both the internal auditors and the NAO are limited.
- 6.12 **We recommend** that the Council should assure itself of the quality of decisions taken under the conduct function by commissioning regular internal and external audits and by ensuring that the terms of the audits provide a sufficient level of scrutiny linked to an evaluation of risk. The internal auditors also need to have the skills and experience necessary to make informed judgements on cases if that is required within the scope of their audit.

The quality of reporting by senior management to the Council and its committees

- 6.13 The Council and its committees were often hampered in undertaking their oversight duties by the quality of information that they received. As discussed above (paragraphs 4.3-4.11) this was partly the result of the absence of a fully functioning IT based case management system. However, on occasion members were provided with misleading information, particularly in relation to how long the decision made in September 2007 not to refer cases to the conduct committee stayed in operation (see paragraphs 4.20-4.29).
- 6.14 There is a discrepancy between the information reported in a draft report of a self assessment against CHRE performance review standards²¹ that was performed in June 2008 by the Quality and Business Efficiency (QBE) section of the Regulation Directorate and the paper to the audit committee²² on 20 June 2008 presenting the report. Examples of the discrepancies include:
- 6.15 CHRE Standard 3.3 – Fitness to practise cases are dealt with in a timely manner at all stages:

¹⁹ GSCC Annual Report and Accounts 2007-08. London: The Stationery Office

²⁰ Chair of the Audit Committee's Annual Report 2008-09 – GSCC Council Meeting 18th May 2009

²¹ CHRE November 2008. The Annual Performance Review Process 2008-2011, Annex A: Standards of Good Regulation

²² Standards of Good Regulation – How the GSCC measures up. Audit Committee 20th June 2008

Draft report – ‘The GSCC Business Plan 2007-2008 aim 2.4.1 refers to suitable, timely decisions and aim 2.4.2 refers to efficient, robust, fair and transparent conduct processes. We are unable to confirm the time taken or service standards, so we are unable to say whether this requirement has been met’ and ‘The GSCC (Conduct) Rules 2003 determine the process for identification and prioritisation of serious cases. Internal policies have been produced but not yet published as being fit for purpose. Therefore, we have not been able to ascertain whether we fully comply with this requirement’.

Report to Audit Committee – ‘We meet this requirement through the Conduct Rules, policies and work instructions. We are reviewing business processes in the light of the GSCC (Conduct) Rules 2008’.

- 6.16 CHRE Standard 3.5 – Decisions made at the initial stages of the fitness to practise process (pre-Fitness to Practise panel stage) are quality assured:

Draft Report – ‘We have not been able to locate the required supporting evidence to meet this requirement. We need to provide documentary evidence that the decisions made at the initial stages of the fitness to practise process are quality assured’.

Report to Audit Committee – ‘We meet this requirement through our Conduct policies and work instructions. We are reviewing business processes in the light of the GSCC (Conduct) Rules 2008’.

- 6.17 These discrepancies and the fact that the information reported to the Audit Committee is not supported by the evidence presented in the draft report raise concerns that the Council has been given unjustified confidence as a result of information provided.
- 6.18 **We recommend** that the executive should be open, transparent and comprehensive when reporting to Council and its committees and should be able to do so with confidence of support through constructive challenge.

7. Purpose and powers of the General Social Care Council

- 7.1 The way in which the GSCC has managed its conduct function in relation to its other roles of education, training, standards and registration suggests that it needs to refocus its activities on the effective delivery of its statutory roles as a regulator. In particular the GSCC does not have, as the health professional regulators do, a statutory duty to protect the public and to promote their care and well-being. This lack of a clear statutory duty to protect the public has contributed to the GSCC failing to deliver an appropriate level of assurance around the standard of conduct and practice amongst social workers.
- 7.2 The core functions of a professional regulator in protecting the public and maintaining confidence in the profession are:
- The setting of standards of professional competence and conduct
 - The setting of standards of education for entry to the register
 - The maintenance of a comprehensive, accurate and accessible register of those fit to practise
 - A fair and timely process for the investigation of complaints and the determination of fitness to practise.
- 7.3 In carrying out these functions a regulator should be able to demonstrate that it observes the principles of good regulation; transparent, accountable, proportionate, consistent and targeted.
- 7.4 **We recommend**, therefore, that the Government reforms the role and legal responsibilities of the GSCC to ensure clarity of purpose in protecting the public and maintaining the standing of the profession to enable it to operate as an effective and independent regulator committed to public protection and to building public confidence in the profession.
- 7.5 In order to have credibility with both the profession and the public a regulator must be seen to be independent of sectional interests. Historically the regulation of professions has grown out of the desire of a profession to secure the quality of its own practice and to protect its standing. Professionals therefore have taken responsibility for the costs of their own regulatory body. Recent reforms in professional regulation mean we have moved away from self-regulation to shared regulation, which is regulation shared between professions and the public in the interests of society as a whole. The new GSCC council is well placed to take forward this model of regulation but we believe its relationship with social work registrants and its independence would be helped by it becoming more financially independent of government and having clearer lines of accountability.
- 7.6 The multiple accountabilities of the GSCC do not seem to have helped to secure effective oversight. The sponsor division is the Professional Standards division, within the Workforce Directorate of the DH. In addition the Social Care Directorate of the DH has an important interest in the implementation of policy while the Department for Children Schools and Families has similar interests in relation to children and young people and the Arms Length Bodies Support Unit sets business planning frameworks.
- 7.7 We recognise that this model will require both a slimmed down and more efficient GSCC and an increase in registration fees for social workers. We therefore consider that this new model of funding should be phased in over a number of

years. We note that this possibility was proposed in the DH Arms Length Bodies (ALB) Review in 2004.

- 7.8 **We recommend** that in the longer term the GSCC becomes more financially independent of the Department of Health and that this change is phased in over a number of years. The GSCC should have more straightforward lines of accountability and oversight.
- 7.9 We are aware that plans are well developed to implement the Government's policy for the GSCC to register other groups of the social care workforce, notably domiciliary care workers and managers. These plans, although delayed, have already occupied considerable amounts of the GSCC's attention and resources. We recognise the seriousness of the discussions which have taken place about the extension of regulation to new groups but note that not everyone is convinced that this is the most proportionate way of managing the risks. This review of the GSCC's conduct function has raised concerns for us about the organisation's capacity to take on the registration of an additional 133 thousand domiciliary care workers and their managers, a workforce which has up to a 20% annual turnover²³.
- 7.10 The recent report of the Extending Professional Regulation Working Party²⁴ concluded that statutory regulation is not always the most appropriate option - balancing the risks of harm and benefit – and that other options may be more appropriate. The evaluation of the Scottish Healthcare Support Workers pilot also suggested that further work was needed to identify if 'a national occupational list would be a proportionate response to the perceived level of risk'²⁵ and concluded that a code of conduct, code of practice and induction standards managed through an employer led approach could be more appropriate. Since the Government's original plans began to take shape we have also seen the development of the regulatory roles of the Care Quality Commission and the Independent Safeguarding Authority in registering domiciliary managers and care workers.
- 7.11 We note too that the addition of new workers to the register will inevitably increase the number of complaints and referrals to the conduct committee.
- 7.12 **We recommend**, therefore, that the Government reviews the risks in relation to the work and supervision of domiciliary care workers and their managers and reconsiders if inclusion in the GSCC's statutory register is proportionate and targeted. Other approaches such as a statutory licensing scheme or an employer-led approach based on codes of conduct and practice and induction standards may be more appropriate.
- 7.13 In achieving the primary goal of improving the standards and performance of social workers the GSCC would benefit considerably from being able to concentrate on the core activities of a modern regulator, the setting of standards, ensuring the quality of education, maintaining a register and ensuring fitness to practise.

²³ England- analysis of the National Minimum Data Set for Social Care (NMDS-SC) 2009

²⁴ *Extending Professional and Occupational Regulation: The Report of the Working Group*, Department of Health 2009

²⁵ *Healthcare Support Workers in Scotland; evaluation of a national pilot of standards and listing in three NHS Boards* Anne Birch & Claudia Martin , Scottish Government Social Research 2009

8. Conclusions and recommendations

- 8.1 This review of the GSCC's conduct function, its management and governance, reveals an organisation looking in another direction. The GSCC's focus on public protection was not as strongly expressed in its conduct function as it should have been possibly because it was giving greater attention to its other statutory duties of developing and improving social work education, establishing a register and maintaining public confidence in social care services.
- 8.2 The GSCC's conduct function was not effective, efficient or well governed. It needs to be if the professionalism of social workers is to be properly supported and challenged to deliver the highest possible practice standards.
- 8.3 There was a failure to appreciate properly the public and organisational risks of weaknesses in the conduct function in particular the consequences of the growing backlog in 2007 and the impact on that of the decision in 2008 to stop referring cases because of financial difficulties.
- 8.4 There was a failure to manage effectively the operation of the conduct team when it was split between offices in Rugby and London so that differences in practice, record keeping and quality were allowed to develop. This was largely due to the lack of a fully functioning case management system.
- 8.5 There was a failure to have accurate management information on the performance of the conduct function so that decisions by the Council and its committees were based on incomplete or inaccurate reports which provided an unjustifiable level of assurance and resulted in decisions based on a false prospectus.
- 8.6 Quality assurance was not consistent across the conduct function allowing inadequate investigations, inconsistent decisions and poor record keeping to prevail.
- 8.7 The work of the GSCC was overseen by two government departments, (including three directorates of the DH), by its internal auditors and by the National Audit Office. It would help the GSCC to have clearer lines of accountability and external oversight.
- 8.8 The new chair of the GSCC, its Council and managers are actively addressing the organisation's problems in the conduct function. An interim chief executive was appointed in July 2009 and has taken immediate action with the Council to bring about improvements. A recovery plan has been developed and is under discussion with the Department of Health. We hope that this report and the recommendations in it will provide a check against that recovery plan and will be a constructive contribution to renewal and significant organisational change.

Summary of Recommendations

- 8.9 **Recommendation 1:** that an effective case management system to support the conduct function should be implemented as a matter of urgency. This must then be supported by oversight by managers who must be responsible for the allocation of cases and ongoing management of the caseload to ensure that appropriate and timely action, including risk assessment, is taken at each stage.
- 8.10 **Recommendation 2:** that KPIs should be developed to measure clear regulatory outcomes. In the short term, the KPIs should reflect the improvements required to the conduct function and will, therefore, enable the GSCC to report on progress

against a valid and effective improvement plan. In the longer term, the KPIs should focus on the progress of cases and the demonstration of public protection.

- 8.11 **Recommendation 3:** that all decisions affecting the progress of cases should be taken on a public protection basis.
- 8.12 **Recommendation 4:** that the two geographically distinct teams and the external investigators should be managed and operated as a single team. Managers need to take a coherent approach with consistent oversight of the function. All processes, deadlines, performance management and allocations and record keeping should be consistent. There should be more regular, formal and structured engagement within the conduct team at the different locations.
- 8.13 **Recommendation 5:** that a conduct team skills audit and development plan should be produced. This should review all staff members' current competencies and identify the competencies required for each role. Where there are discrepancies, training needs should be identified and appropriate training should be provided.
- 8.14 **Recommendation 6:** that the GSCC and DH should review the current primary and secondary legislation relating to the conduct process and replace it with a fitness to practise process which allows it to assess conduct and competence.
- 8.15 **Recommendation 7:** the conduct committee should be given the power to use all of the sanctions now available to the fitness to practise committees/panels of the majority of the health professional regulators. The DH should consider this in the context of CHRE's work on harmonising sanctions across health professional regulators²⁶.
- 8.16 **Recommendation 8:** the relevant legislation should be amended so that appeals against decisions made by the conduct committee are heard by the High Court rather than the Care Standards Tribunal.
- 8.17 **Recommendation 9:** that the GSCC should adopt a lower threshold of referral of cases to the conduct committee. Cases should be referred if there is a realistic prospect of a sanction being imposed. This must be incorporated into the relevant guidance for staff. The availability of conditions as a sanction would greatly aid a proportionate approach to fitness to practise.
- 8.18 **Recommendation 10:** that with immediate effect all new cases are risk assessed, including being signed off promptly by a person with sufficient competence and authority. Ongoing risk assessments should be completed within similar timescales. The risk assessment should include consideration of whether there is a need for an ISO.
- 8.19 **Recommendation 11:** that comprehensive guidance on good file management should be given to all staff, and that managers should ensure that it is complied with routinely and that all files are capable of being audited.
- 8.20 **Recommendation 12:** that the GSCC should attempt to strengthen its relationships with employers in relation to conduct issues, with the aim of increasing the level of co-operation and information sharing. The Government should provide the GSCC with additional powers to require employers and others to provide information or concerns about a social worker's fitness to practise to the GSCC.
- 8.21 **Recommendation 13:** that the GSCC should give clear reasons when they close a case explaining why the social worker should not be referred to the conduct

²⁶ Council for Healthcare Regulatory Excellence, 2008. *Harmonising Sanctions, CHRE's position*. London, CHRE

committee on the basis that they do not present a risk to the public. The GSCC should also clarify, and strictly apply, its policies on how to handle social workers who have not renewed their registrations and those who apply for voluntary removal whilst under the conduct process.

- 8.22 **Recommendation 14:** that Council and Committee members should provide effective scrutiny by challenging information provided and requiring senior management to demonstrate what they have done to address identified issues.
- 8.23 **Recommendation 15:** that the GSCC review their approach to risk management to ensure that it is effective in identifying, recording and managing risks within the organisation. Where required, training should be provided. This should include Council members, senior management and all operational staff.
- 8.24 **Recommendation 16:** that the Council should assure itself of the quality of decisions taken under the conduct function by commissioning regular internal and external audits and by ensuring that the terms of the audits provide a sufficient level of scrutiny linked to an evaluation of risk. The internal auditors also need to have the skills and experience necessary to make informed judgements on cases if that is required within the scope of their audit.
- 8.25 **Recommendation 17:** that the executive should be open, transparent and comprehensive when reporting to Council and its committees and should be able to do so with confidence of support through constructive challenge.
- 8.26 **Recommendation 18:** that the Government reforms the role and legal responsibilities of the GSCC to ensure clarity of purpose in protecting the public and maintaining the standing of the profession to enable it to operate as an effective and independent regulator committed to public protection and to building public confidence in the profession.
- 8.27 **Recommendation 19:** that in the longer term the GSCC becomes more financially independent of the Department of Health and that this change is phased in over a number of years. The GSCC should have more straightforward lines of accountability and oversight.
- 8.28 **Recommendation 20:** that the Government reviews the risks in relation to the work and supervision of domiciliary care workers and their managers and reconsiders if inclusion in the GSCC's statutory register is proportionate and targeted. Other approaches such as a statutory licensing scheme or an employer-led approach based on codes of conduct and practice and induction standards may be more appropriate.

Annex 1 – Secretary of State written ministerial statement

Regulation of Social Care

The Secretary of State for Health (Andy Burnham): The General Social Care Council (GSCC) is the professional regulatory body for social workers in England and has statutory responsibility for investigating complaints against social workers. In June, the Department of Health became aware that a backlog of conduct referrals had developed at the GSCC and liaised with GSCC to determine the scope and nature of the problem.

On 2 July, Ministers were alerted as the GSCC had identified a backlog in the management of 203 complaints against social workers registered with it. Ministers were very concerned about any risk to the public and met the Chair and Chief Executive of the GSCC on 6 July to seek reassurances from them. The Council reported that there were 21 cases where the allegations, though unproven, suggested that there could have been an ongoing risk of harm to members of the public.

Ministers asked the Council to ensure that urgent action was taken to address any potential threat to public safety that could arise if these individuals were continuing to work as social workers, by establishing their whereabouts, to ensure that any who were still in employment were being safely and appropriately managed while the allegations were investigated. GSCC has been working to ensure that any employers of these individuals are aware of the allegations made and to ensure that the individuals concerned have not sought employment elsewhere.

On Friday 17 July, the Department received information from the GSCC regarding all 21 cases. The GSCC confirmed that either the individuals concerned are employed as social workers by known employers who are aware of the allegations that have been made and are managing any risks or, as far as the Council can ascertain, they are not currently employed as social workers.

In the light of Ministers' concerns around public safety, my officials facilitated a team to work with GSCC to ensure that all cases in the backlog were reviewed to determine if any were high risk. Following this review, a small number of other cases have been identified which are being investigated. Ministers are seeking urgent further assurances that every possible step has now been taken to ensure that none of these individuals present a current risk.

In all cases where the GSCC has assessed that there may be a potential ongoing risk, panels are scheduled to have met by Friday 24 July to consider the imposition of an interim suspension order on the individual in question pending the outcome of the GSCC's investigations.

The fact that a backlog of conduct referrals, some of which had not been adequately risk assessed, has built up is a matter of extreme concern. We understand that GSCC has therefore suspended its Chief Executive while it looks into how the issue arose.

As an interim measure, Paul Philip, currently Deputy Chief Executive at the General Medical Council, is joining GSCC as acting chief executive.

The Department of Health is today commissioning the Council for Healthcare Regulatory Excellence to carry out a wide-ranging review of the governance and performance of the GSCC. The purpose of the review is to establish what further action is needed to ensure that Ministers, Parliament and the public can have confidence that the GSCC is effectively carrying out its statutory duties to promote high standards of conduct and practice in order to protect the public. The GSCC supports the review, which will report to Ministers by the end of September.

20 July 2009

Annex 2 – Terms of Reference: review of GSCC’s conduct function

1. Objectives

1.1 The review will provide:

- An appraisal of the effectiveness, efficiency and governance of GSCC’s current and planned conduct processes in delivering public protection and value for money.
- Recommendations to improve the effectiveness, efficiency and governance of GSCC’s conduct processes.
- Comparative information about policy and practise in the management and governance of conduct cases across similar health and social care regulators and consequent risk assessment.

1.2 In June 2009, the GSCC notified the Department of a backlog of 203 unallocated conduct cases, some of which posed a risk to public protection and several cases which were more than 12 months old. Earlier this year the CHRE, at the invitation of the GSCC, conducted a limited review of a sample of the GSCC’s conduct cases which also reported in June. This raised concerns about the management of the GSCC’s conduct work.

2. Review Requirement

2.1 To provide an independent and objective appraisal of GSCC’s current and planned conduct processes in delivering public protection and value for money. This will include:

- **Backlog**

1. Reviewing how a backlog of conduct cases was allowed to develop.
2. Examining how the backlog was not identified as a significant risk.
3. Assessing whether appropriate systems have been put in place to prevent another backlog reoccurring.

- **Risk assessment and management**

4. Assessing whether risk assessment is effective and carried out in all cases, including referral for interim suspension orders.
5. Considering whether the threshold set for pursuing conduct cases reflects good practice in public protection.

- **Governance of the conduct function**

6. Assessing whether management information systems are robust and provide adequate assurance to senior GSCC management, Council and government.
7. Assessing whether the governance of the GSCC’s conduct function by the Council is effective.
8. Assessing whether the Conduct Rules are effective.

9. Considering the level of management oversight of the conduct function and scrutiny by the Audit and Regulation Committees.

- **Benchmarking efficiency and effectiveness**

10. Assessing the relative effectiveness and efficiency of GSCC's conduct function compared to comparable regulators.

- **Conduct priority and culture**

11. Assessing whether conduct is given sufficient priority within GSCC and whether the organisational culture is focused on and aligned with delivering public protection.

- **Evidence gathering and appraisal**

12. Considering whether the GSCC has effective mechanisms and relationships for obtaining information on concerns about the conduct of registrants from employers, the police, the Independent Safeguarding Authority and others for the better protection of the public.

13. Reviewing whether the GSCC makes sufficient assessments about the information it received about the conduct of registrants and where necessary uses its powers of investigation effectively.

- **Application of healthcare regulation principles**

14. Considering whether the principles for Healthcare regulators set out in the *White Paper, Trust, Assurance and Safety* should also apply to the GSCC.

3. Principles of good regulation

3.1 The review should take account of the five principles of good regulation. These state that any regulation should be:

- Transparent
- Accountable
- Proportionate
- Consistent
- Targeted

4. Review arrangements

4.1 The Review will be led by a senior representative of the Council for Healthcare Regulatory Excellence with support from independent auditors. It will assess the outputs of this work and decide on the conclusions to be drawn.

DH will ensure the review team is able to draw on sufficient expertise and resource and help to facilitate cooperation of relevant stakeholders.

4.2 The review will present a report to the Department of Health's Permanent Secretary by the end of September 2009 and will be published after consideration by DH and DCSF Ministers. The report will provide an independent assessment of the current situation and recommendations to improve the efficiency and effectiveness of GSCC's conduct function to enhance public protection and stakeholders' confidence

in the GSCC. Recommendations will be evidence-based, proportionate, legal and have due regard to equality and human right considerations.

July 2009

Annex 3 – Audit sample

How we carried out the audit of conduct cases and selected the sample of cases

1. Process of the audit

1.1 In auditing a sample of GSCC cases we followed as far as possible the process we have developed for our audits of the nine health professional regulators. In these audits of the nine regulators we examine a sample of cases that the regulators have closed in the initial stages of their fitness to practise processes. These are cases that they close without referring to a final stage fitness to practise panel hearing. The process and guidelines document for those audits can be found on our website:

www.chre.org.uk/Audit_Process_and_guidelines_April_2009.pdf

1.2 There are two main questions that we consider when reviewing a regulator's handling of cases:

- whether its staff have followed the regulator's own guidance and procedures.
- whether any decision to close a case failed, or risked failing, to protect the public, either through presenting a direct risk to members of the public or failing to maintain public confidence in the profession and the system of regulation.

1.3 To assess this we look at:

- The reasonableness of the handling and the outcomes of the sampled cases.
- The information each case gave about the processes and supporting environment in which cases are handled, and the risk that future cases might not be handled appropriately.

2. Selection of sample at the GSCC

2.1 We were initially invited to audit a sample of GSCC conduct cases in April 2009. For that first audit we selected, entirely at random, 20 cases from all those closed by the GSCC, without reference to a final conduct hearing, in the year 2008/09.

2.2 In our second audit, carried out in August 2009, we examined a further 102 cases. In selecting these we broadly adopted the sampling method that we apply in our audits of the health professional regulators. However, we adapted this because of the wider remit of the review that this audit was supporting. We did not limit ourselves to cases that were closed in the financial year starting April 2008, nor to those cases closed without reference to a final hearing. We also reviewed some cases that were still open.

2.3 We selected a random sample from a range of cases handled by the GSCC since October 2007. We also included, in a separate section of our sample, all the cases falling within certain categories – this is explained further below.

2.4 Until recently the GSCC allocated a case number for each matter reported to them. The number allocated was sequential. Therefore to achieve a random selection of cases closed at all stages we called for every 14th number in this sequence to a total

of 50 case reference numbers of cases opened since April 2008. The sample of cases provided gave us cases closed at all the possible stages of the GSCC process, apart from those matters closed at very early stages by the new initial screening department (“CIAS”) which has operated since April 2009. We therefore also requested a sample of 20 of those CIAS cases.

- 2.5 We found that the initial sample of 50 cases under-represented the work of the London based team. This is because of the way that the GSCC has operated recently, with a majority of new cases being allocated to the Rugby-based teams, and because the Rugby team has conducted most of the work before a matter is referred for formal investigation. We therefore also reviewed all the cases closed by the London team in the period April 2008 to August 2009. Where the matter had been closed by the final conduct committee we considered the reasonableness of the outcome, but had available the supporting files to help address any further queries we had.
- 2.6 To help us gain a slightly broader historic view, we also made a random selection of cases closed between 1 October 2007 and 31 March 2008.

Annex 4 – List of people we spoke to

We are grateful to the following current and former Council members who have met with us and given their time to contribute to this review.

Rosie Varley	Chair
Melanie Henwood	Chair, Regulation Committee
David Prince	Chair, Audit Committee
Sir Rodney Brooke	Former Chair

We are also grateful to the considerable number of staff members who met with us and who were very helpful in providing information.

We also spoke to

David Behan	Director General Social Care, Department of Health
Gavin Larner	Head of Standards & Regulation, Department of Health

Annex 5 – List of organisations invited to submit evidence

ADCS (Association of Directors of Children's Services)

ADASS (Association of Directors of Adult Social Services)

LGA (Local Government Association)

BASW (British Association of Social Workers)

SOLACE (Society of Local Authority Chief Executives)

UNISON

Unite (the Union)

Council for Healthcare Regulatory Excellence

11 Strand

London WC2N 5HR

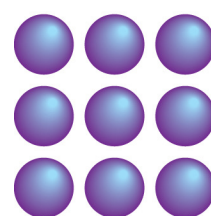
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